



**COMMUNITY PROFILE**

**OCTOBER 21, 2010**



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## 1.0 Background

The purpose of this report is to provide stakeholders with a picture of what is happening locally in Leeds, Grenville and Lanark in relation to the six priority areas described below. The report is by no means exhaustive, and will be added to as more data becomes available.

Tri Health, the Leeds, Grenville and Lanark Heart Health Coalition, alongside other coalitions such as the Smiths Falls FOCUS Coalition and Safe Communities, has played a pivotal role in supporting health promotion initiatives within our community since its formation in 1998. In 2009 the Ministry of Health Promotion and Sport announced a change in focus from heart health to creating communities where the healthy choice is the easiest choice. To facilitate this change, the Ministry announced that the Healthy Communities Fund would replace the Heart Health Network.

The vision of the Healthy Communities Fund is “healthy communities working together and Ontarians leading healthy and active lives.” The specific goals of the framework are to:

- Create a culture of health and well-being
- Build healthy communities through coordinated action
- Create policies and programs that make it easier for Ontarians to be healthy
- Enhance the capacity of community leaders to work together on healthy living

In order to achieve these goals, the framework consists of three components: a Grants Project Stream, Partnership Stream and Resource Centre. The Grants Project Stream provides funding to local and provincial organizations for projects in 6 priority areas, while the Partnership Stream promotes coordinated planning and action among community partners to create policies that make it easier for Ontarians to be healthy. The Resource Centre helps to build the capacity of Partnerships and communities by providing training and support to build healthy communities.

The Healthy Communities Fund specifies six priority areas with examples of recommended actions:

- **Physical activity, sport and recreation**
  - Access to recreation and physical activity
  - Support active transportation & improve the built environment
- **Injury prevention**
  - Promote safe environments that prevent injury
- **Healthy eating**
  - Access to healthier food
  - Educate and develop food skills
- **Tobacco use/exposure**
  - Access to tobacco-free environments and smoking cessation services
  - Educate the public about the risks of tobacco
- **Substance & alcohol misuse**
  - Increase resiliency in youth
  - Engage youth in alcohol misuse prevention strategies
- **Mental health**
  - Increase resiliency in youth

Taking an integrated approach to these six priority areas will help to make Ontario communities, including Lanark, Leeds and Grenville, healthier.

Following the introduction of the Healthy Communities Fund, Tri Health members agreed to remain involved and function as an Interim Steering Committee in order to lay the foundation for the Healthy Communities Partnership Lanark, Leeds and Grenville (HCP LLG) as part of the Partnership Stream. To date, this has included:

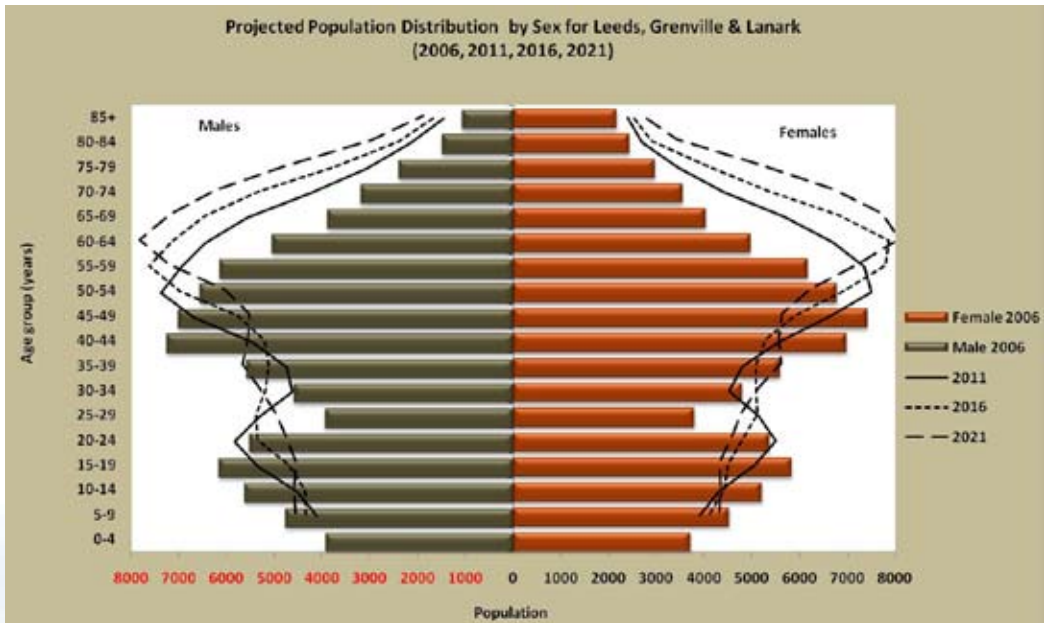
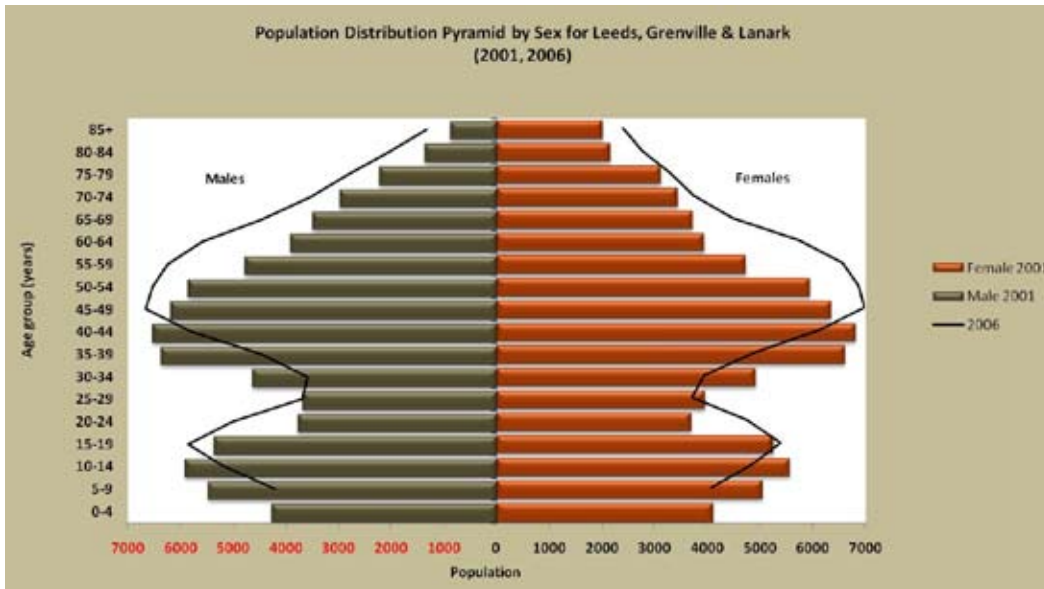
- Collecting and analyzing local data related to the six priority areas
- Collecting data on existing assets
- Informing and involving various stakeholders
- Organizing a partnership day to share information about the Healthy Communities Fund
- Sharing local data and assets and inviting members to form the HCP LLG
- Acquiring training necessary to set local priorities



## 2.0 Demographics

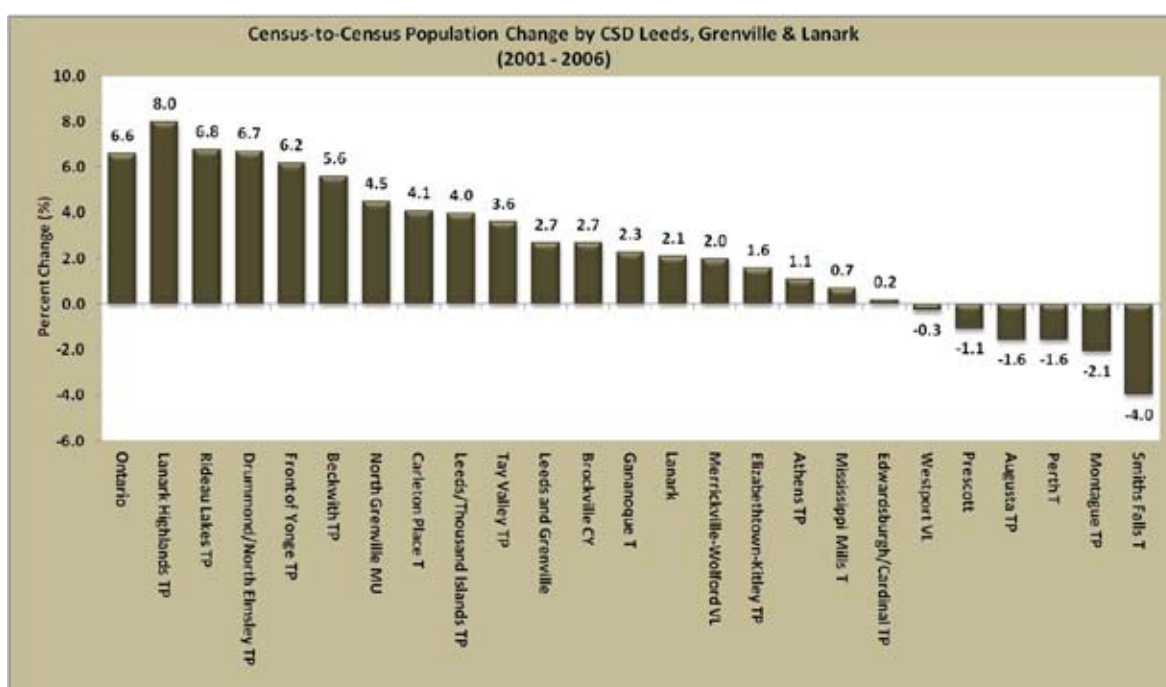
The Ministry of Health and Long Term Care has classified the Leeds, Grenville and Lanark Health Unit as a Mainly Rural Health Unit. The total population of Leeds, Grenville and Lanark was 162 990 with a population density per square kilometre of 26.9 in 2007. The geographic area covers 6 329 square kilometres. Local government consists of 2 Counties and 21 Municipalities with multiple small towns and hamlets. The largest urban area is the City of Brockville, population 21 957 (2006 census). There is a 3.7% Francophone population, zero First Nations bands, and a 7.6% immigrant population.

The population of LGL increased by 2.4% between the 2001 and 2006 censuses; the greatest positive rate of population change occurred in the 55+ age groups and the greatest decrease in population occurred in the 0-4 and 5-14 year age groups. As the population pyramids below illustrate, the projected population of Leeds-Grenville and Lanark will shift towards an older age cohort over the next 14 years.



58% of residents in LGL live in a rural environment compared with 16% for Ontario overall. Average family incomes in Lanark and in Leeds-Grenville are similar: \$78 333 and \$74 422, respectively. The unemployment rate for the period of October 10, 2010 to November 6, 2010 is 8.3%<sup>1</sup>, and 9.4% of families are below the Low-Income Cut-Off (LICO). In terms of family structure, 74.0% of residents are married couple families, 12.9% are common law families, and 13.1% are single parent families. 54.1% of residents have completed post-secondary education and 18.4% have completed less than secondary school.

Breaking down the population of Leeds-Grenville and Lanark by census sub-division is a good method for visualizing where population increases and decreases are occurring. As the figure below illustrates, Lanark Highlands Township experienced the greatest rate of growth (8.0%) between 2001-2006, and the Town of Smiths Falls experienced the greatest population decrease (-4.0%) during this time period.



Source: 2001 and 2006 Census of Canada, Statistics Canada

When comparing the income and education levels of LGL, several characteristics are noteworthy. The town of Prescott has the lowest median income level, and the lowest proportion of the population without a certificate, diploma or degree (i.e. low education). The town of Smiths Falls follows closely behind Prescott and has the second lowest median income level and second lowest education level. Beckwith Township has the highest median income level and highest education levels, followed by Mississippi Mills and North Grenville. Income and social status along with education and literacy are two of the key determinants of health, with health status improving at each step up the income hierarchy and with increasing levels of education<sup>2</sup>.

1 Human Resources and Skills Development Canada. "Economic Region of Eastern Ontario (2000)." <http://srv129.services.gc.ca/eiregions/eng/eastont.asp?rates=1&period=262> (Accessed 13 October 2010).

2 Public Health Agency of Canada. "What Makes Canadians Healthy or Unhealthy?" <http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php> (Accessed 13 October 2010).



### 3.0 Methodology

The data in this report are primarily from Statistics Canada (the Census), the Canadian Community Health Survey (CCHS), the Rapid Risk Factor Surveillance Survey (RRFSS) and the Ontario Student Drug Use and Health Survey (OSDUHS).

The CCHS provides cross-sectional estimates of health determinants, health status and health system utilization for 133 health regions across Canada, plus the territories. The target population is household residents ages 12 and over. CCHS data can be analyzed specifically for Leeds-Grenville and Lanark and compared to the province. Appendix 1 (p.41) provides details about the CCHS variables analyzed for this report.

The RRFSS is an ongoing telephone survey used to gather surveillance data, monitor public opinion on key public health issues, and collect information on emerging issues of importance to public health in Ontario. Local data for Leeds-Grenville and Lanark are collected and analyzed on an ongoing basis for adults ages 18 and older.

The OSDUHS is a population survey of Ontario students in grades 7 to 12. This self-administered, anonymous survey is conducted across the province every two years with the purpose of identifying epidemiological trends in student drug use, mental health, physical activity, and risk behaviour, as well as identifying risk and protective factors. Typically, the OSDUHS surveys thousands of students in over 150 elementary and secondary schools across Ontario. For the 2009 survey OSDUHS incorporated six Ontario public health units, including the Leeds-Grenville and Lanark District Health Unit, as regional strata to provide better regional estimates for these health units. This provides local data for LGL students which can be compared to other students in the province who completed the survey.

Data analyses were conducted using SPSS software (SPSS Inc., Chicago, IL, Version 18). Microsoft Excel spreadsheet software was used to produce charts and graphics (Excel; Microsoft Inc., Redmond, WA, Version 2007). The descriptive analysis focussed on calculation of percentages and associated 95% confidence intervals (95% C.I.) (See following paragraphs for a description of confidence intervals).

#### What is a confidence interval?

A confidence interval is a range of values that is normally used to describe the uncertainty, or alternately, the precision around a point estimate (%) of a quantity. The confidence interval is dependent on the sample of data on which it is calculated. Therefore we describe a 95% confidence interval as having a 95% probability of covering the true value, rather than saying that there is a 95% probability that the true value falls within the confidence interval.

#### Confidence intervals as statistical tests

When comparing two rates to determine if they are statistically significantly different, we use confidence intervals to see if the observed rates are different from each other beyond what would be expected by sampling error (chance) alone. Confidence intervals can allow for the quick determination of these differences if they exist.

If two rates from the same overall population have confidence limits that overlap then they are said to be not statistically significantly different. However, if two confidence intervals do not overlap, a comparable statistical test would always indicate a statistically significant difference.

**Note:** point estimates accompanied by an "\*" have a high sampling variability and should be interpreted with caution.



## 4.0 Data: Healthy Communities Priority Areas

### Highlights:

**60.9%** of LGL residents report having less than 5 daily servings of fruit and vegetables

**40.8%** of LGL residents report being 'moderately active' to 'active' based on average daily energy expenditure – this is significantly lower than the provincial average

**Falls** are the leading external cause of emergency department visits for LGL residents age 0-9 and age 65+

**23.6%** of LGL residents report smoking cigarettes daily or occasionally and 45.5% of grade 12 students in LGL report lifetime use of tobacco

**12.5%** of secondary students in LGL report alcohol use once a week or more in the past 12 months and 18.4% of LGL secondary students report using cannabis 10+ times in the past 12 months

**21.7%** of LGL residents (ages 12+) report 'quite a bit' to 'extreme' life stress and 8.7% of LGL students (grades 7-12) report that they 'seldom/never' feel good about themselves

**59.9%** of LGL residents are overweight or obese





### 4.1 Healthy Eating

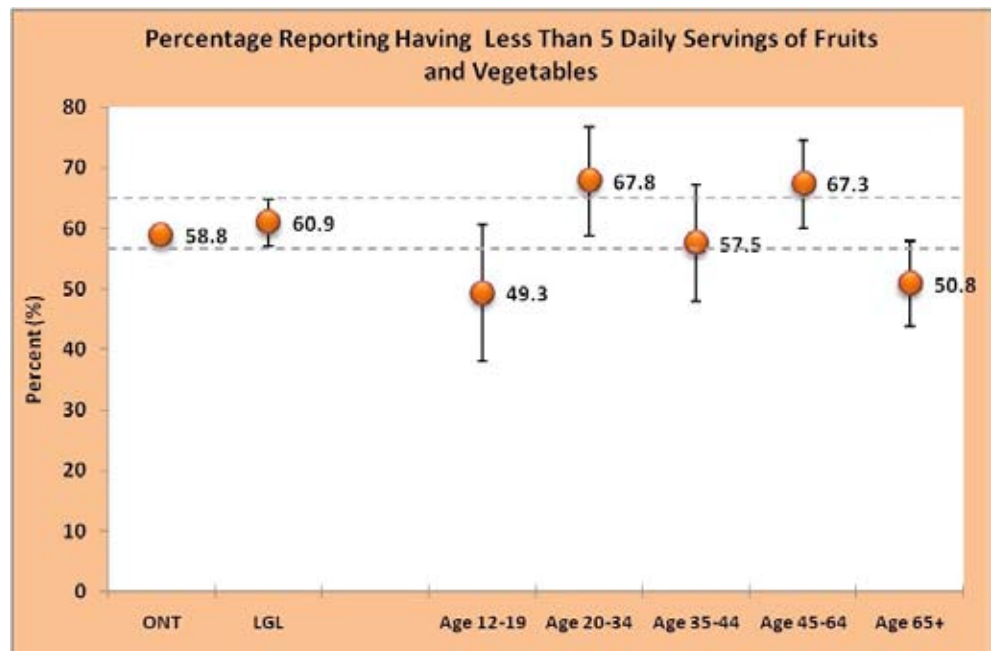
Canada’s Food Guide outlines recommendations for amounts and types of food based on a person’s age and sex. For vegetables and fruit servings, Canada’s Food Guide recommends the following:

Canada’s Food Guide: Vegetables and Fruit Serving Recommendations

Age 2-3	4 servings
Age 4-8	5 servings
Age 9-13	6 servings
Female age 14-18	7 servings
Male age 14-18	8 servings
Female age 19-50	7-8 servings
Male age 19-50	8-10 servings
Age 51+	7 servings

#### Fruit & Vegetable Consumption by Age Group

The percentage having less than 5 daily servings of fruit and vegetables in LGL is not significantly different than the rates for Ontario. The youngest (age 12-19) and oldest (age 65+) age groups appear to consume more fruits and vegetable servings.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

- The 2004 CCHS: Nutrition survey found that over one-quarter (25.4%) of Canadians ages 19 or older and 24.8% of youth ages 4-18 had eaten ‘at least some fast food’ in the past 24 hours<sup>1</sup>
- The majority of Canadians in all age groups (including children, youth, adults and older adults) reported usual sodium intake above the tolerable upper intake level: in the 19-30 age group 98.8% of males exceeded the upper intake level and 76.3% of females exceeded the upper intake level (CCHS: Nutrition 2004)<sup>2</sup>
- A Canadian study of children’s eating behaviours (grades 4-8) found that only 60.1% of girls and 70.0% of boys ate breakfast every day; that girls were less likely to eat breakfast everyday compared to boys; and that fewer students ate breakfast as grade increased<sup>3</sup>

1 Garriguet, D. “Overview of Canadians Eating Habits 2004”. Statistics Canada, July 2006.

2 Garriguet, D. “Sodium Consumption at All Ages”. Health Reports 18 (2): May 2007.

3 Evers S et al. “Eating and Smoking Behaviours of School Children in Southwestern Ontario and Charlottetown, PEI”. Canadian Journal of Public Health 92, 6 (2001): 433-436.

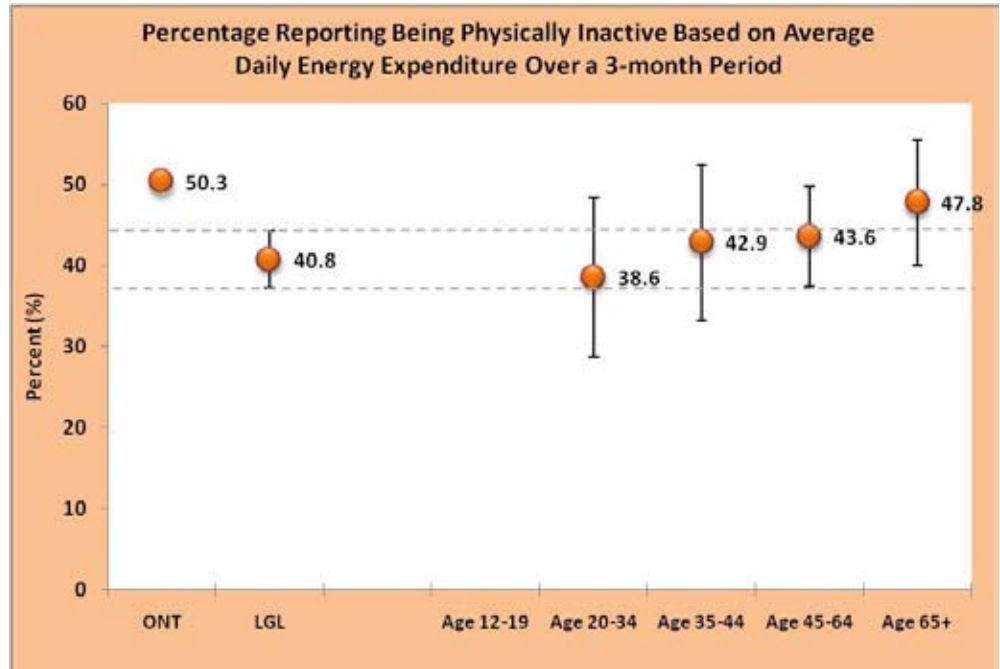


## 4.2 Physical Activity, Sport and Recreation

Canada's Physical Activity Guide to Healthy Active Living provides recommendations for Canadians. The guide recommends daily physical activity based on the intensity of the activity: 60 minutes of light effort; 30-60 minutes of moderate effort; or 20-30 minutes of vigorous effort.

### Physically Inactive by Age Group

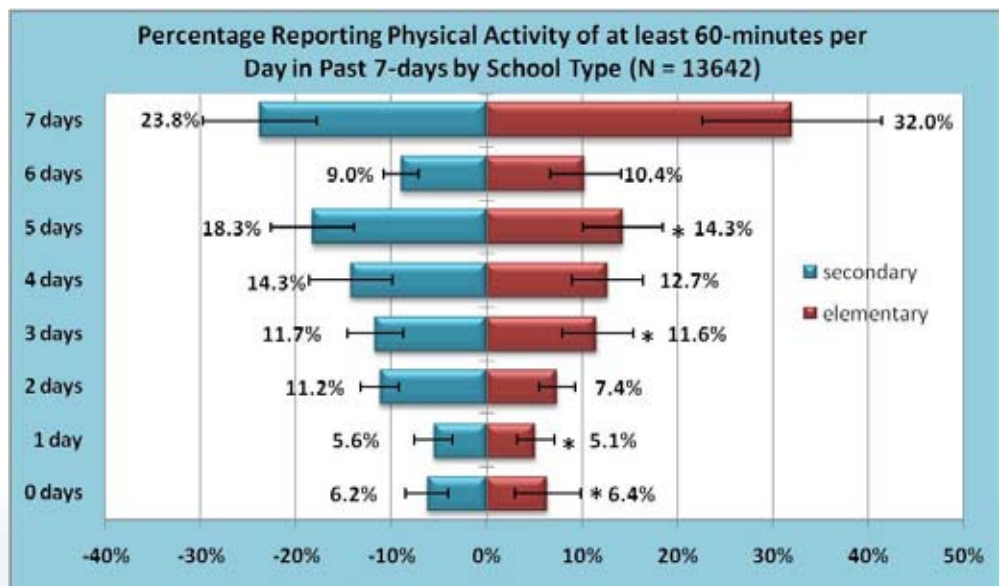
The proportion of LGL residents who are physically inactive is significantly lower than Ontario. Physical activity levels appear to decrease with age in LGL, although not significantly.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

### Physical Activity by School

More elementary students in LGL (grade 7 and 8) are active for 60 minutes a day, 7 days a week compared to secondary students.

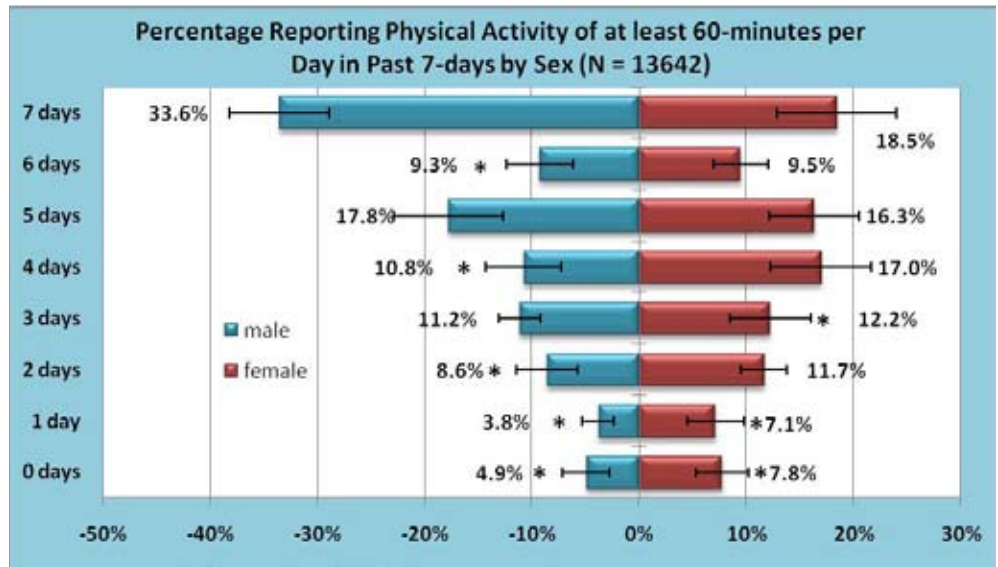


Source: Ontario Student Drug Use and Health Survey, CAMH 2009



**Physical Activity by Sex**

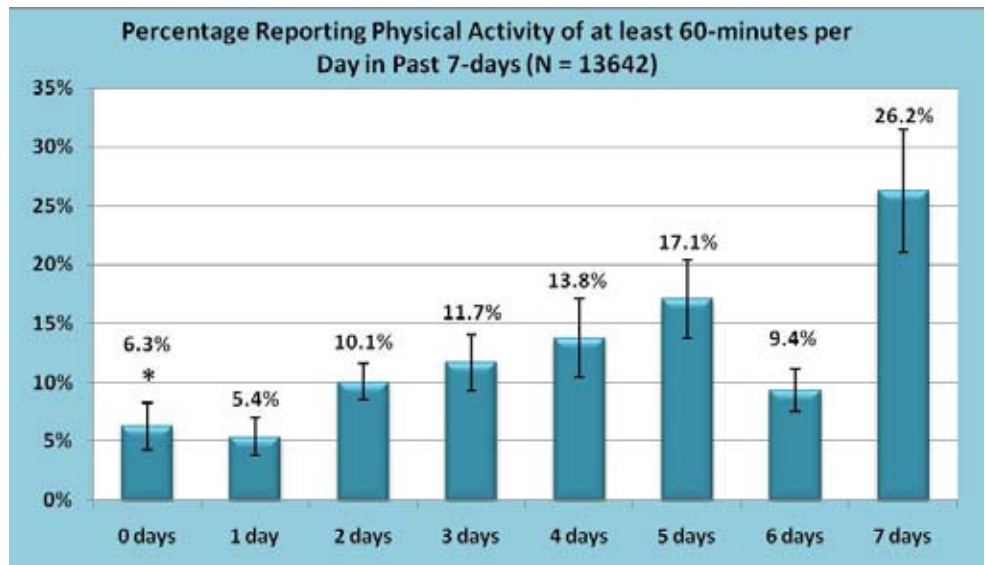
Male students in LGL are significantly more active for 60 minutes a day, 7 days a week compared to female students.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Physical Activity Overall**

52.7% of students in LGL are active for at least 60 minutes a day, 5 or more days per week.



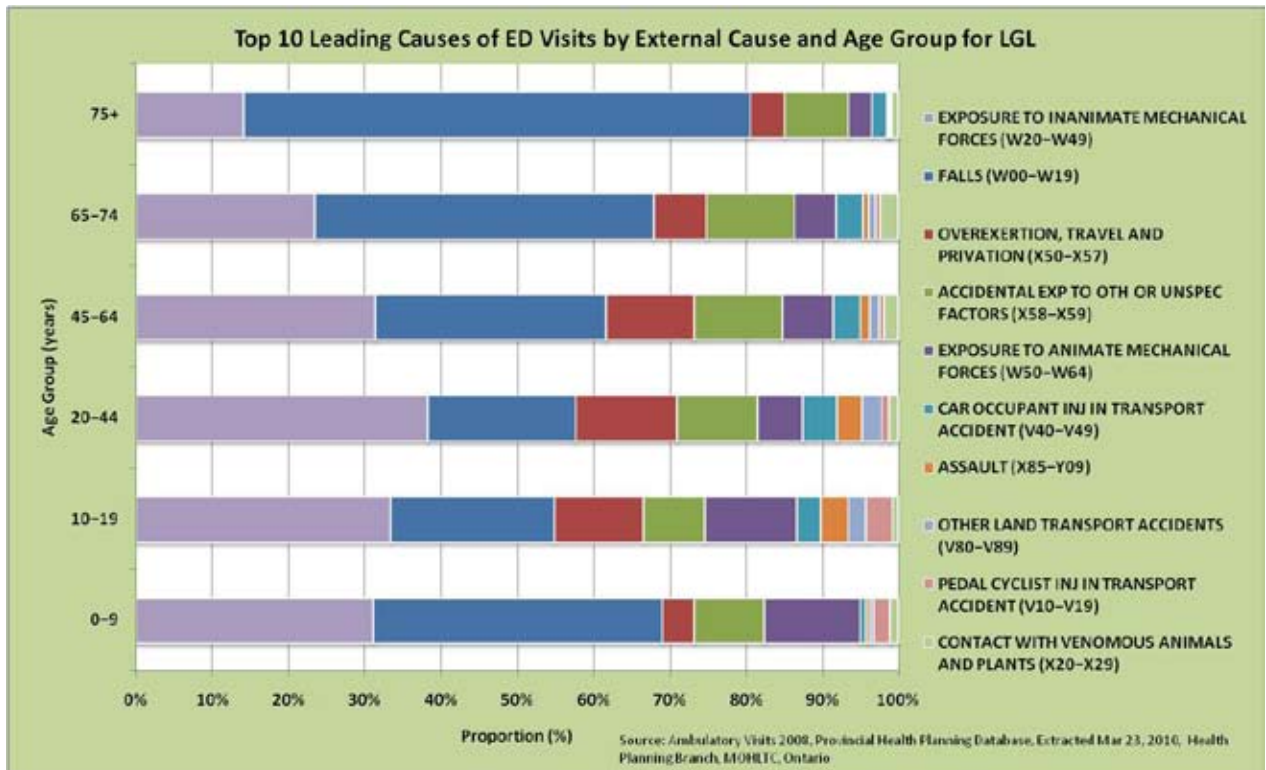
Source: Ontario Student Drug Use and Health Survey, CAMH 2009

- Youth (ages 12-19) in LGL have an average of 19.7 hours of screen time in a typical week (hours of computer use, watching television or watching videos)<sup>4</sup>

4 Canada Fitness and Lifestyle Research Institute. "Rating Canada's Regional Health: Which Region Accumulates the Most Screen Time?" <http://www.cflri.ca/eng/regionalhealth/index.php> (Accessed 27 Sept 2010).



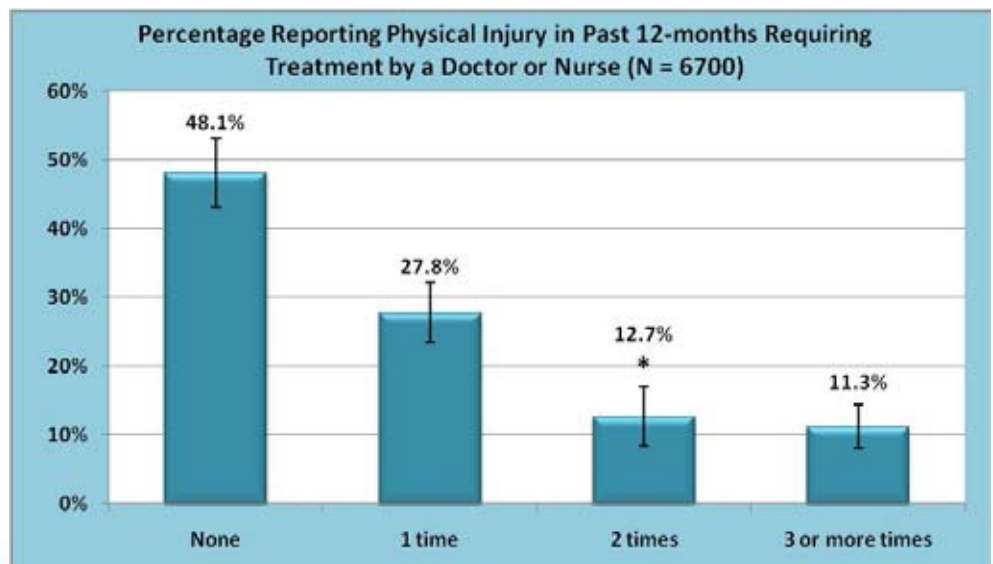
### 4.3 Injury Prevention



Falls are the leading cause of emergency department visits in the youngest (age 0-9) and oldest (age 65+) age groups.

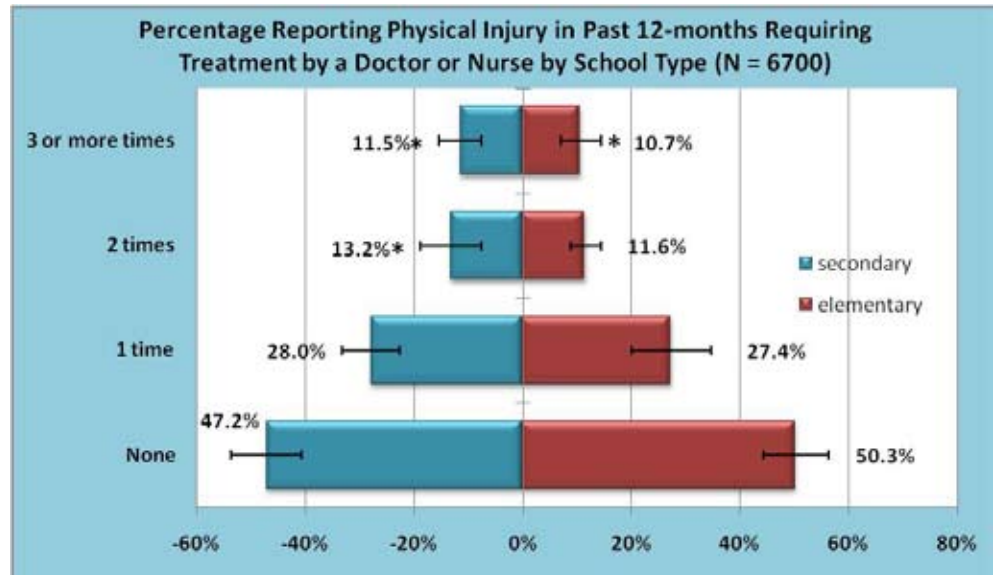
### Injury Overall

51.8% of students in LGL reported a physical injury in the past 12 months requiring treatment by a doctor or nurse one or more times.



**Injury by School**

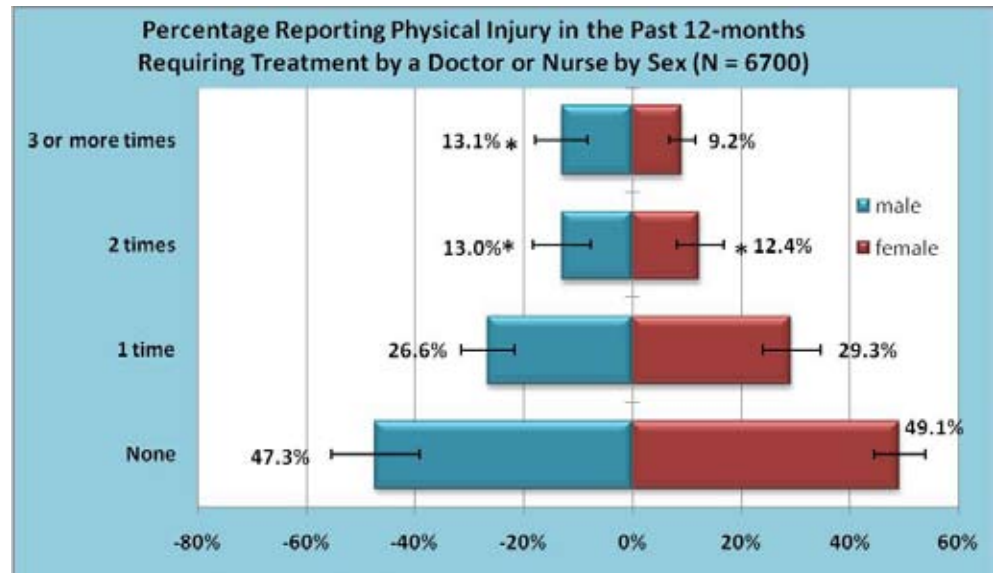
The proportions of elementary and secondary students in LGL reporting physical injuries in the past 12 months requiring treatment by a doctor or nurse are similar.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Injury by Sex**

The proportions of male and female students in LGL reporting physical injuries in the past 12 months requiring treatment by a doctor or nurse are similar.



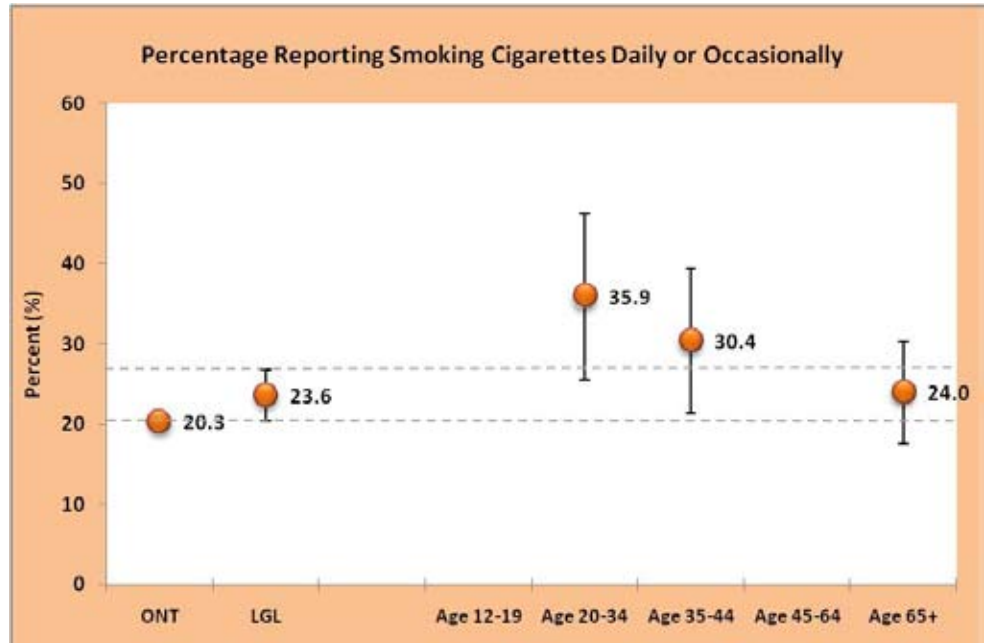
Source: Ontario Student Drug Use and Health Survey, CAMH 2009



## 4.4 Tobacco use/Exposure

### Tobacco by Age Group

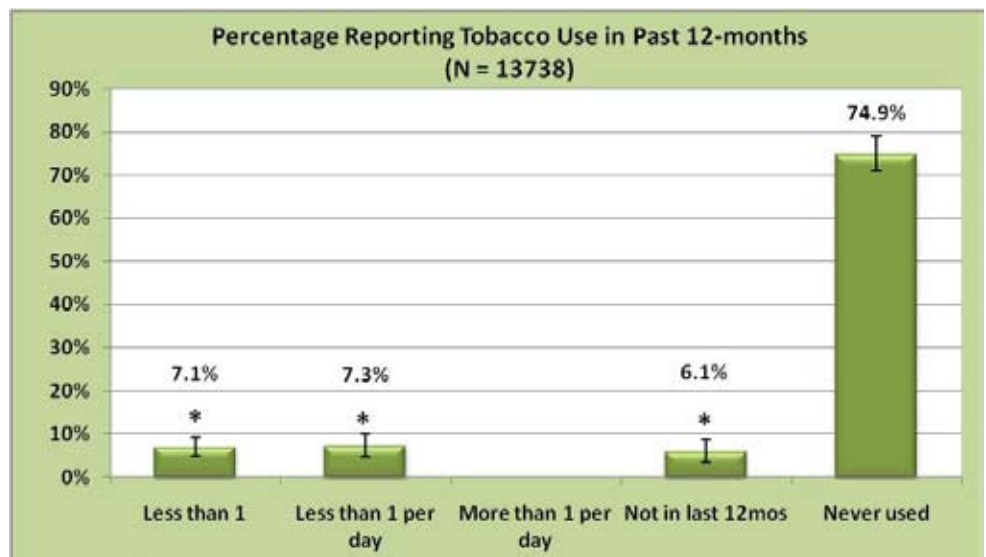
The percentage of LGL residents who report smoking cigarettes daily or occasionally is slightly higher than the provincial average. Daily or occasional cigarette smoking among LGL residents decreases with age, although not significantly.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

### Tobacco Overall

Overall, close to three-quarters of students in LGL (74.9%) report that they have never used tobacco in the past 12 months, while 6.1% report using tobacco but not in the past 12 months, and slightly over 7% report smoking less than 1 whole cigarette or smoking less than 1 cigarette per day.

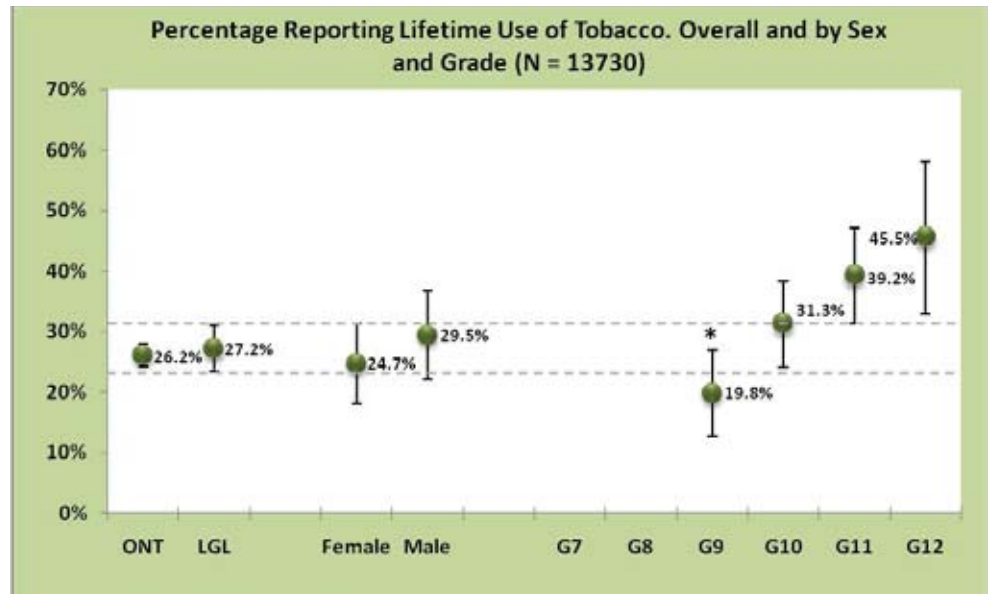


Source: Ontario Student Drug Use and Health Survey, CAMH 2009



**Tobacco Lifetime**

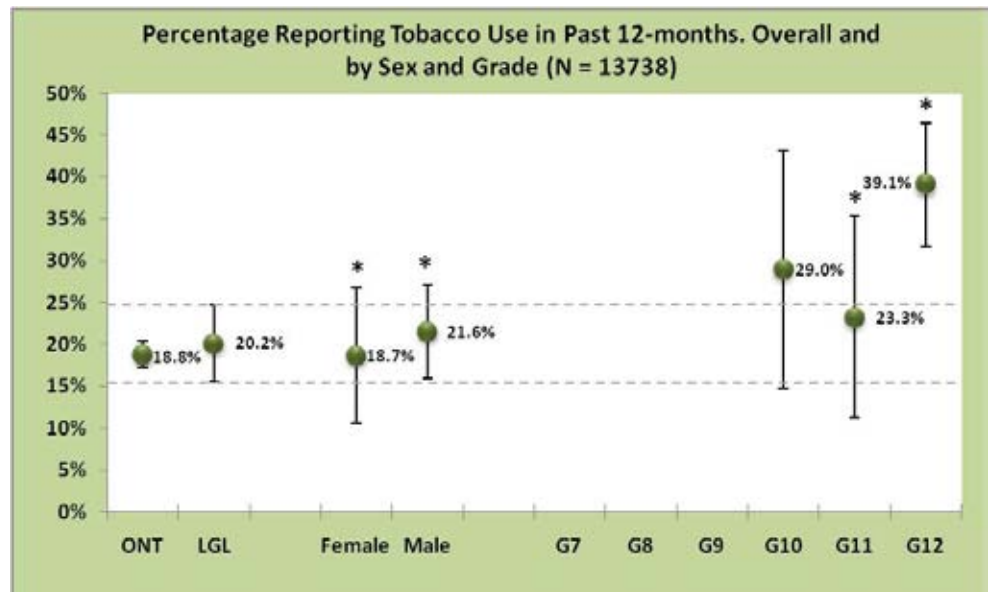
The percentage of LGL students reporting lifetime use of tobacco increases with grade, such that the percentage reporting lifetime use by grade 12 is significantly higher than grade 9. As well, male lifetime tobacco use is slightly higher than female lifetime tobacco use, although not significantly.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Tobacco by Past Year**

More male LGL students reported tobacco use in the past year than female students, although not significantly. As well, the percentage of LGL students reporting tobacco use in the past year is slightly higher than the provincial average, but again, not significantly.

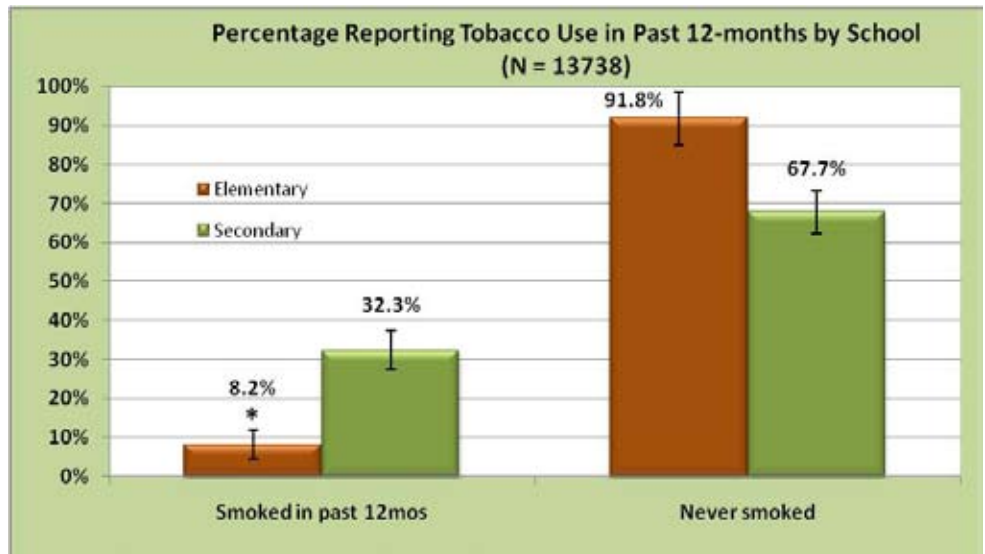


Source: Ontario Student Drug Use and Health Survey, CAMH 2009



### Tobacco by School

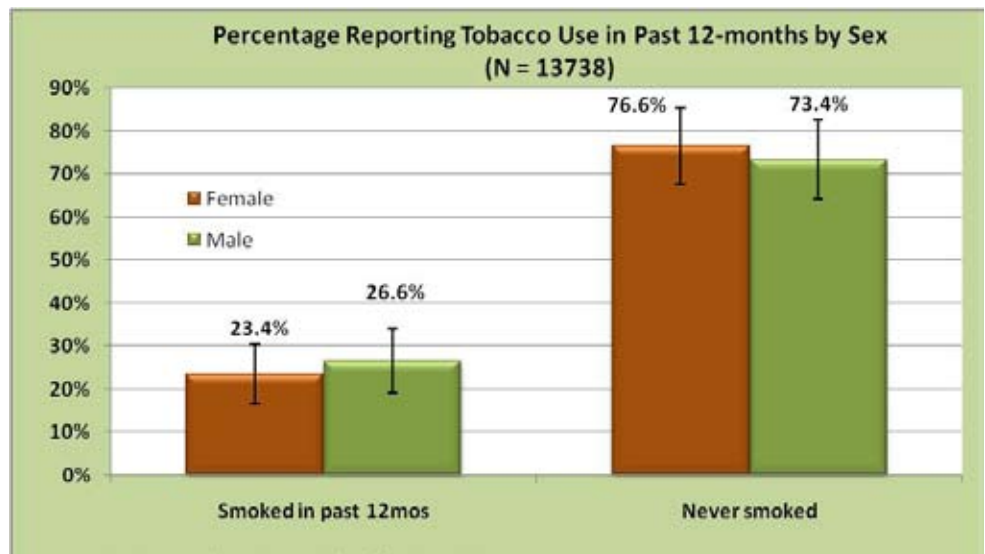
The percentage of LGL secondary students who report smoking in the past 12 months is significantly higher than LGL elementary students. As well, the percentage of LGL elementary students reporting to have never smoked is significantly higher than LGL secondary students.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

### Tobacco by Sex

There are no significant differences between tobacco use in the past year for male and female students in LGL. 23.4% of female students and 26.6% of male students report tobacco use in the past 12 months.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

- 16.9%\* of LGL residents reside in a home where someone smokes cigarettes regularly and 18.1%\* of LGL residents are exposed to second-hand smoke everyday (RRFSS 2008 and RRFSS 2007; \*data have high variability and should be interpreted with caution).





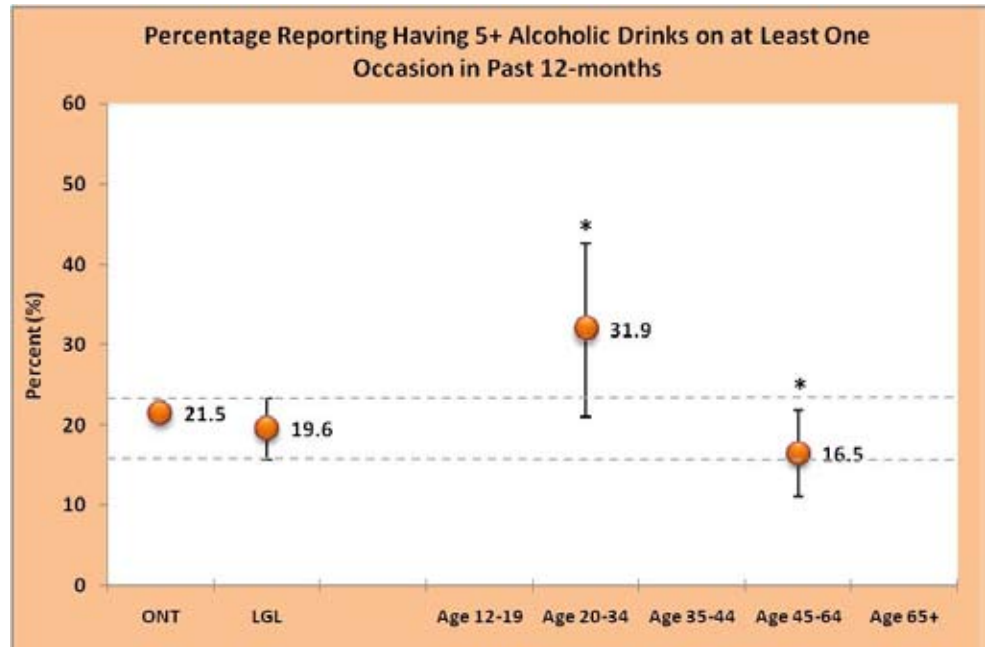
### 4.5 Substance Misuse/Alcohol Misuse

The Centre for Addiction and Mental Health has established low-risk drinking guidelines for Canadians of legal drinking age. The guidelines state:

<b>0 drinks</b>	Lowest risk of an alcohol-related problem
<b>2 drinks</b>	No more than 2 standard drinks on any one day
<b>9 drinks</b>	Women: Up to 9 standard drinks a week
<b>14 drinks</b>	Men: Up to 14 standard drinks a week

#### Alcohol by Age Group

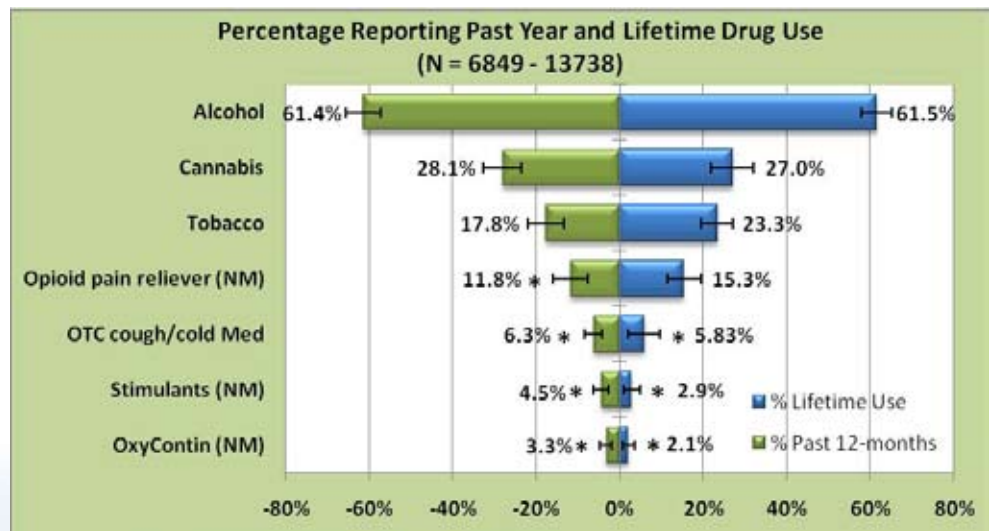
Close to 1 in 5 LGL residents (19.6%) report having 5+ drinks on at least one occasion in the past 12 months.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

#### Past Year vs. Lifetime Drug Use

Alcohol is the most commonly used drug by students in LGL followed by cannabis and tobacco. The proportions of LGL students reporting drug use in the past 12 months and lifetime use are similar.

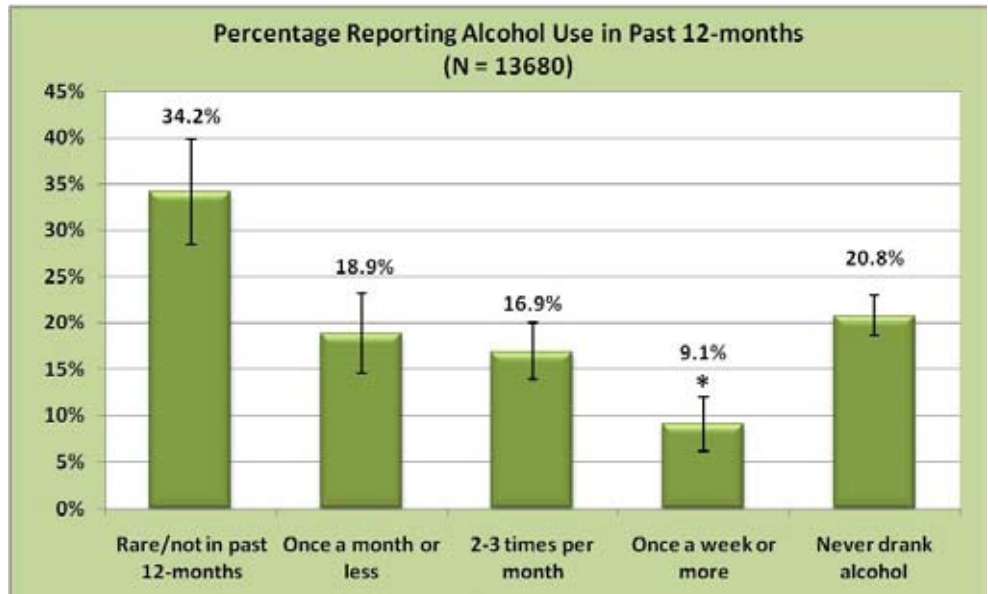


Source: Ontario Student Drug Use and Health Survey, CAMH 2009



**Alcohol Overall**

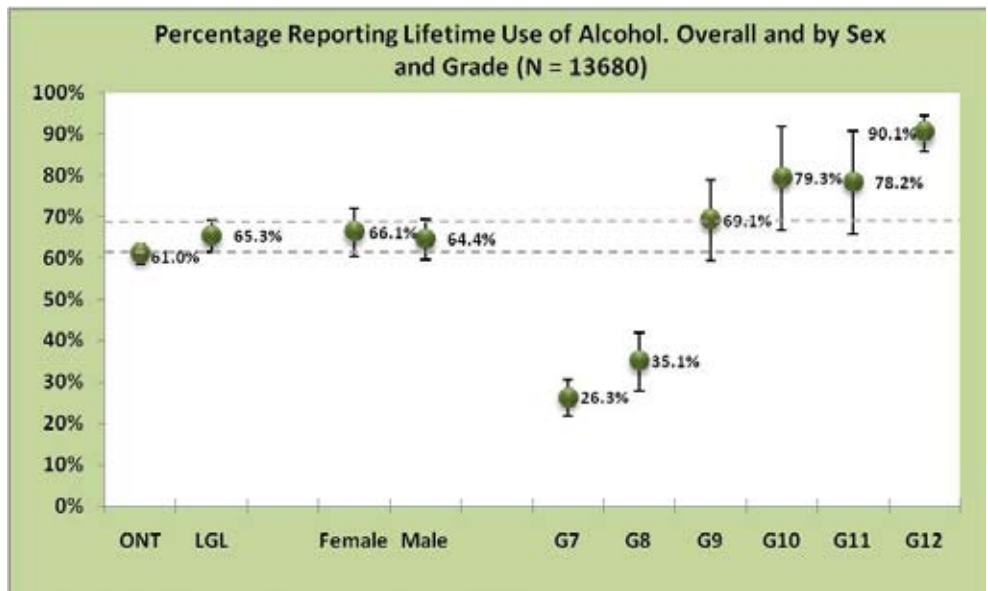
16.9% of LGL students report drinking alcohol 2-3 times per month and 9.1% report drinking alcohol once a week or more.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Alcohol Lifetime**

Although the percentage of LGL students who report lifetime use of alcohol is higher than Ontario, it is not a significant difference. Lifetime use among male and female LGL students is very similar, and lifetime use increases as grade increases, with lifetime use by secondary students significantly higher than lifetime use by elementary students.

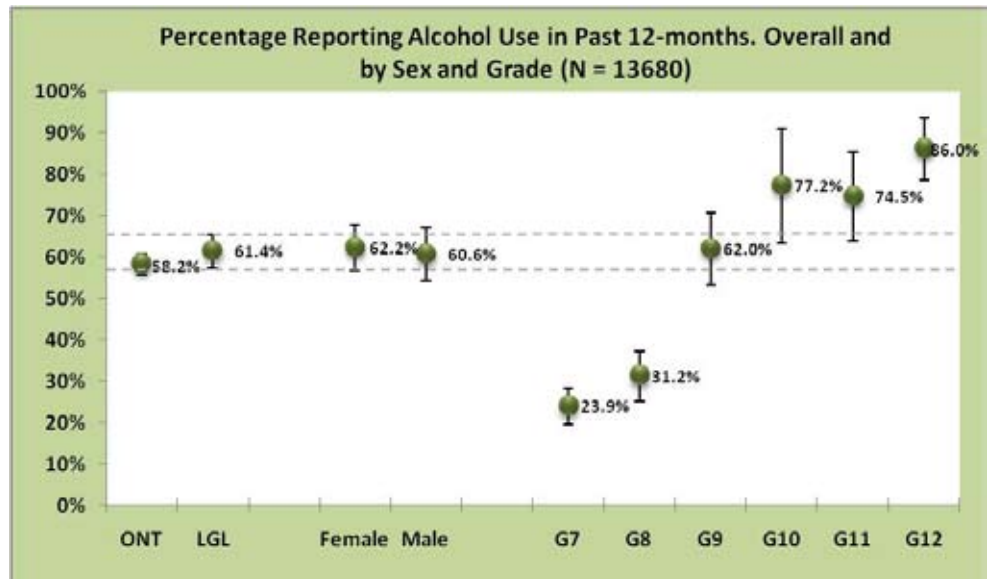


Source: Ontario Student Drug Use and Health Survey, CAMH 2009



**Alcohol Past Year**

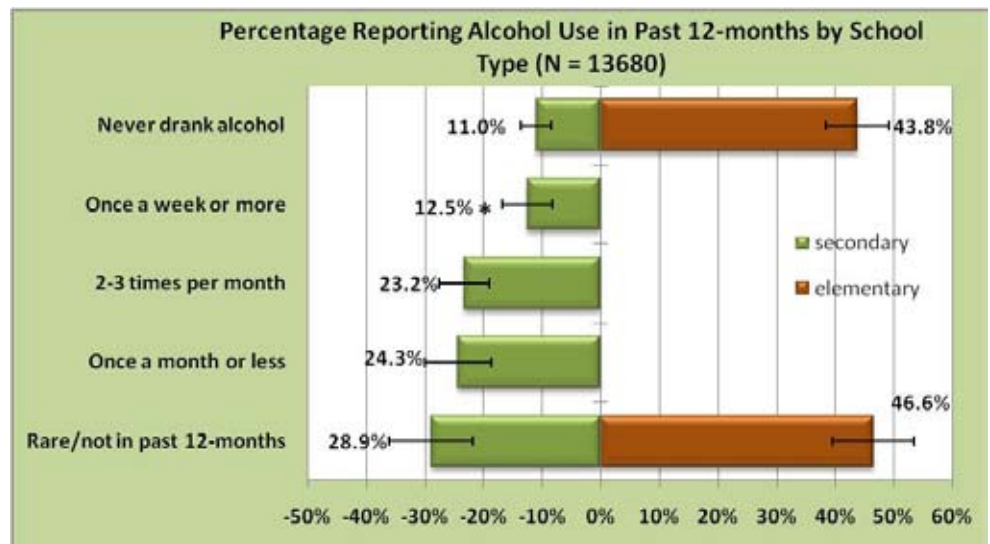
Although the percentage of LGL students who report use of alcohol in the past year is higher than Ontario, it is not a significant difference. Alcohol use in the past year among male and female LGL students is very similar, and alcohol use increases as grade increases, with alcohol use by secondary students significantly higher than alcohol use by elementary students.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Alcohol by School**

The percentage of LGL elementary students who have never drank alcohol is significantly higher than the percentage of LGL secondary students who have never drank alcohol.

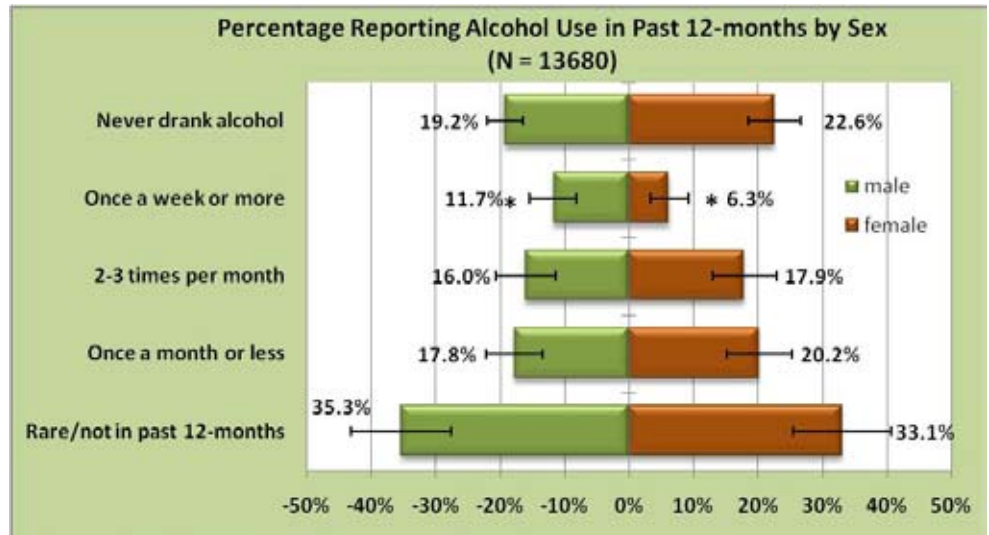


Source: Ontario Student Drug Use and Health Survey, CAMH 2009



**Alcohol by Sex**

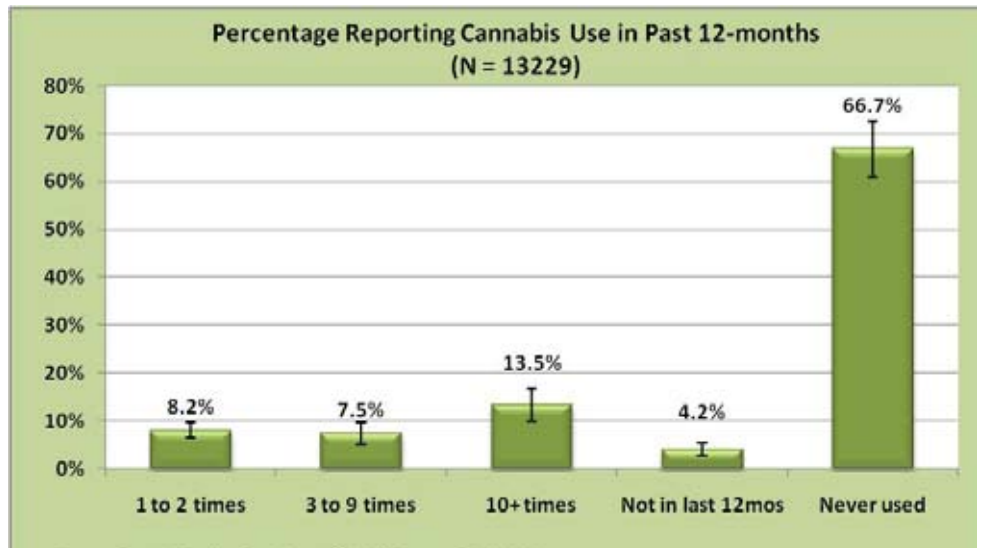
Alcohol use among male and female LGL students is quite similar with no significant differences.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Cannabis Overall**

Overall, 21.0% of LGL students report that they have used cannabis 3 or more times in the past 12 months.

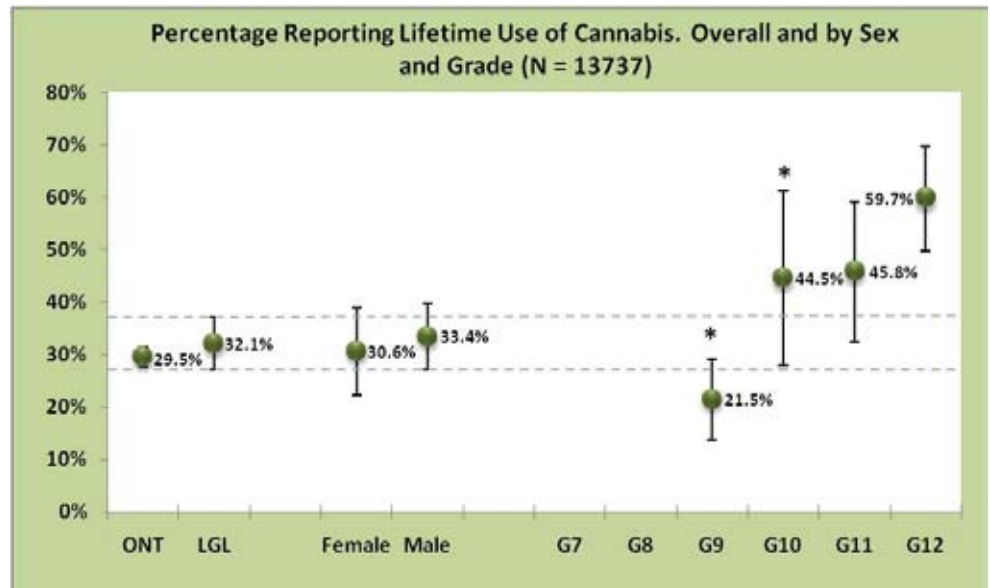


Source: Ontario Student Drug Use and Health Survey, CAMH 2009



**Cannabis Lifetime**

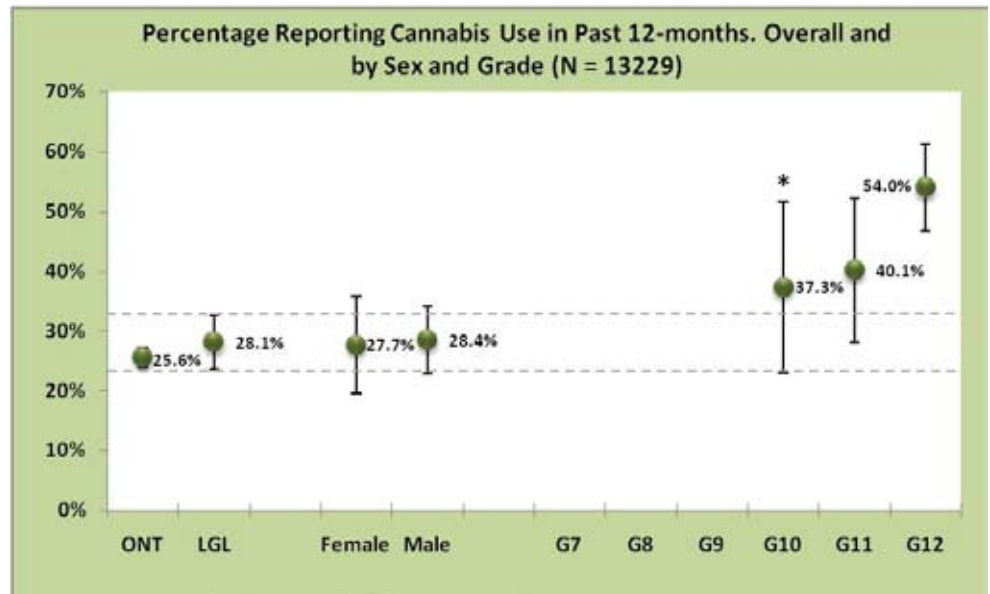
Lifetime use of cannabis increases with grade, with 59.7% of grade 12 students reporting lifetime use compared to 21.5% of grade 9 students.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Cannabis Past Year**

Although the percentage of LGL students reporting cannabis use in the past 12 months is higher than Ontario, it is not a significant difference. Male and female use is very similar, and cannabis use increases with grade.

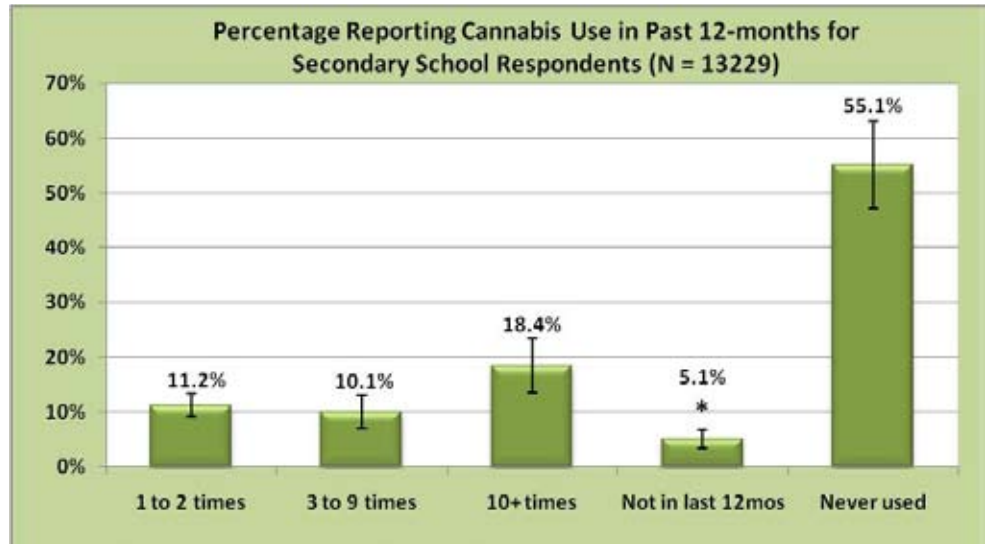


Source: Ontario Student Drug Use and Health Survey, CAMH 2009



**Cannabis by School**

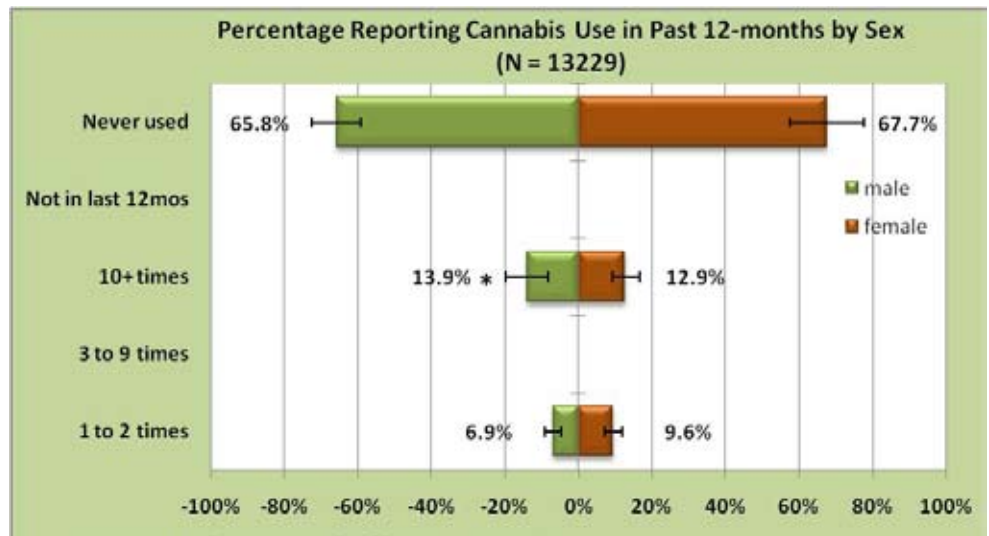
18.4% of secondary school students in LGL reported using cannabis 10+ times in the past 12 months.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Cannabis by Sex**

The proportions of male and female LGL students who report using cannabis are similar without any significant differences.



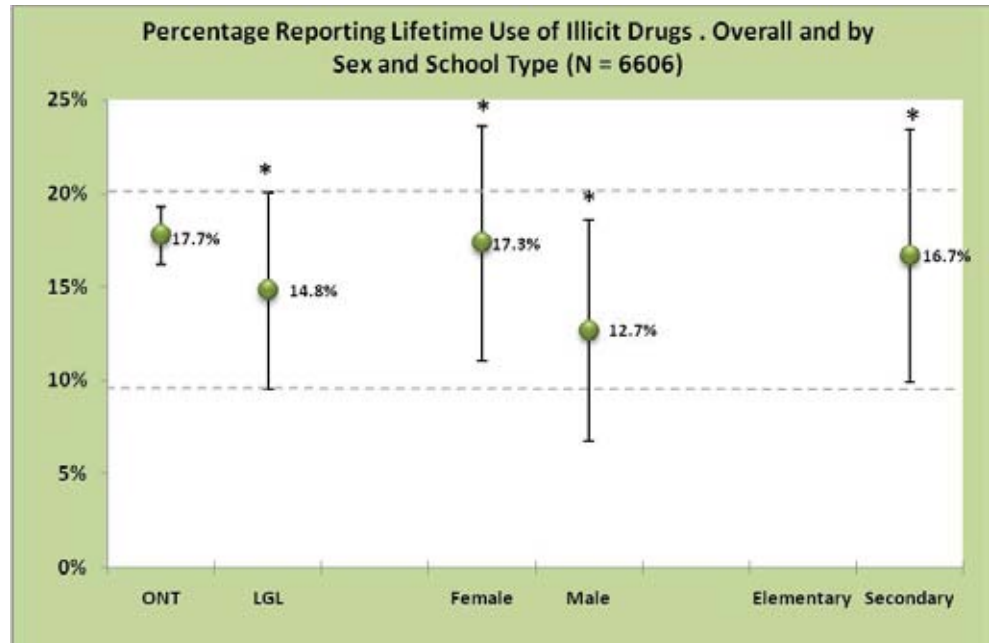
Source: Ontario Student Drug Use and Health Survey, CAMH 2009



**Illicit drugs lifetime**

The OSDUHS defines the illicit drug use variable as “derived from the combination of the following: sniffing of glue or solvents, heroin, methamphetamines, crystal meth, LSD, PCP, crack, cocaine, ecstasy, GHB, rohypnol, ketamine, jimson weed, and salvia divinorum, but excludes cannabis and non-medical prescription drug use”.

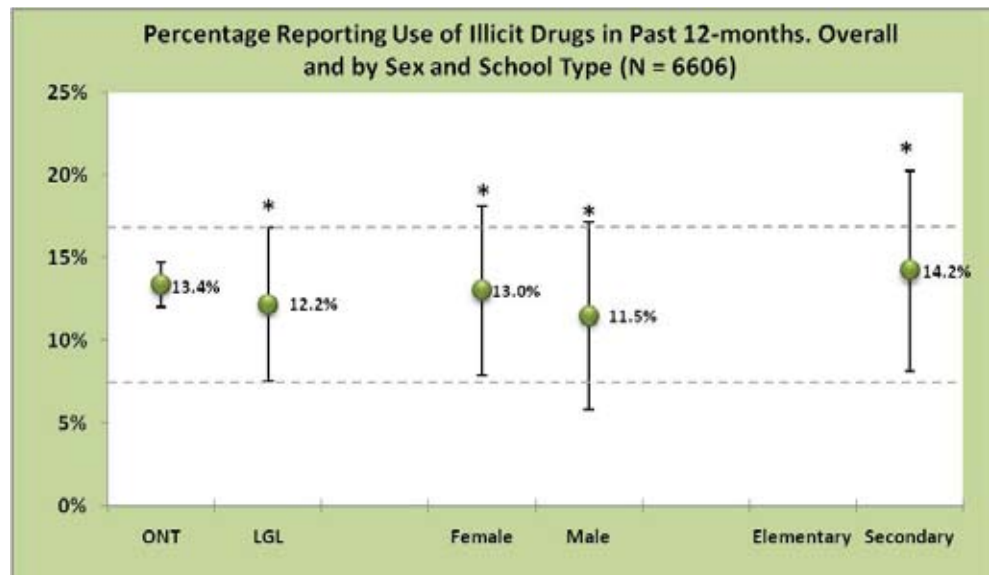
*There are no significant differences in lifetime use of illicit drugs between LGL students and Ontario. As well, there are no significant differences between males and females (although females report higher lifetime use).*



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Illicit Drugs Past Year**

*There are no significant differences in use of illicit drugs in the past year between male and female students in LGL or between students in LGL and students in Ontario.*



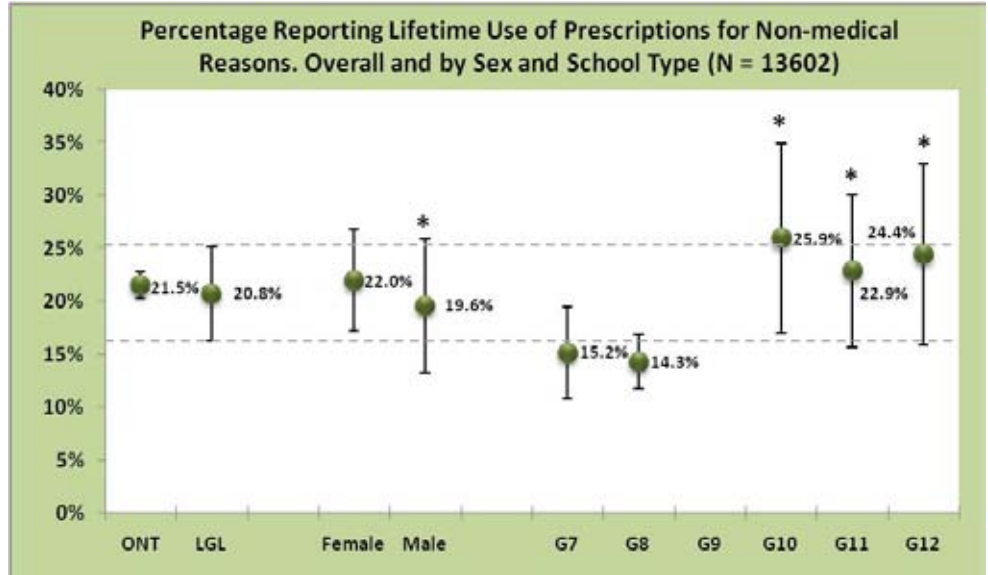
Source: Ontario Student Drug Use and Health Survey, CAMH 2009



**Non-Medical Prescription Use Lifetime**

The OSDUHS defines the non-medical prescription use variable as “derived from the combination of the non-medical use of: opioid pain relievers, oxycontin, ADHD drugs and sedatives/tranquilizers”.

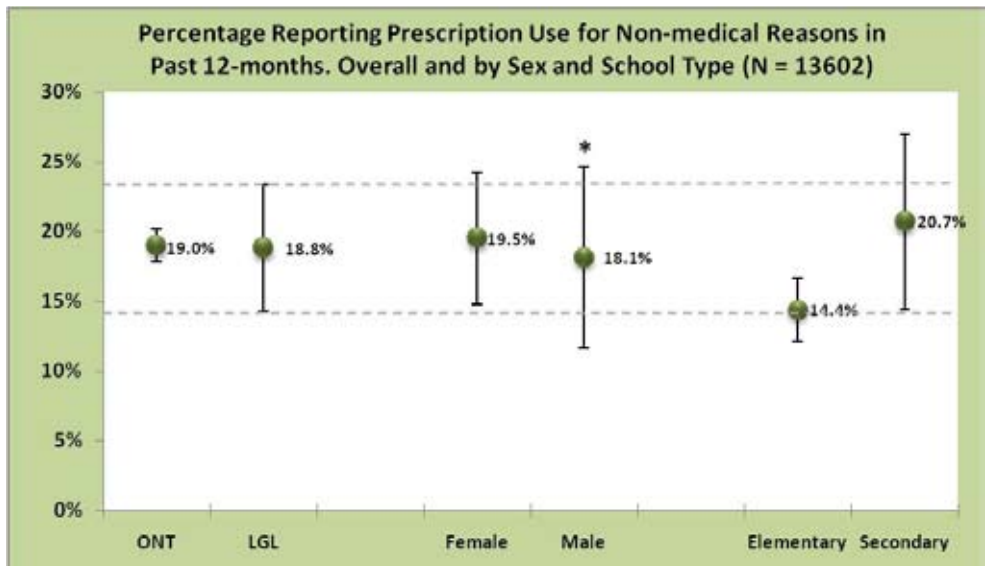
*There are no significant differences in lifetime use of prescriptions for non-medical reasons between male and female students in LGL or between students in LGL and students in Ontario.*



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Non-Medical Prescription Use Past Year**

*Use of prescription drugs for non-medical reasons in the past 12 months is higher among secondary students in LGL than elementary students. There are no significant differences between students in LGL and students in Ontario, or between male and female students in LGL.*



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

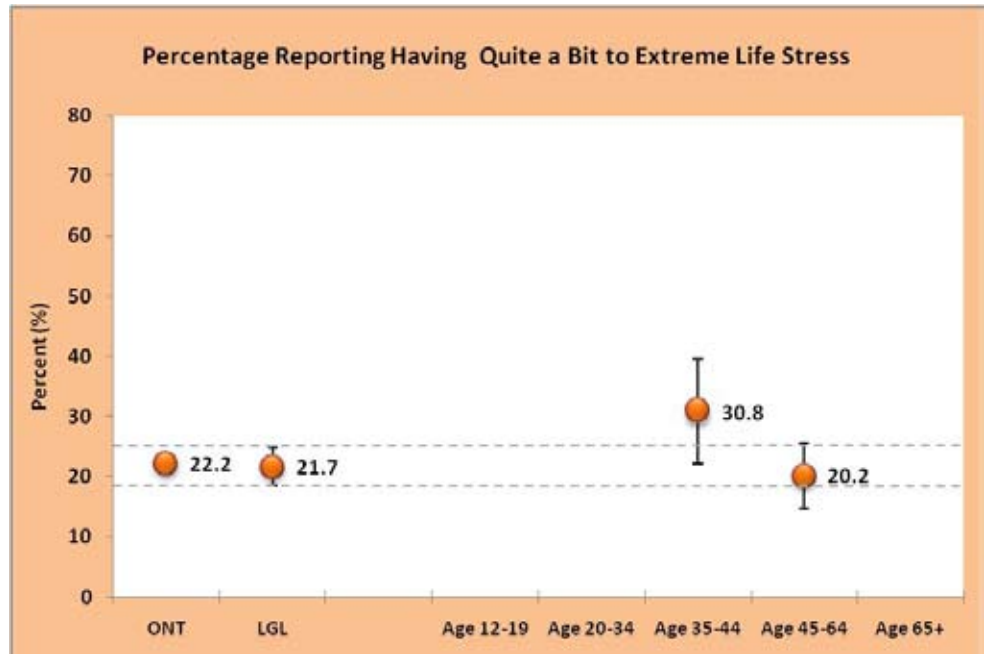




## 4.6 Mental Health

### Stress by Age Group

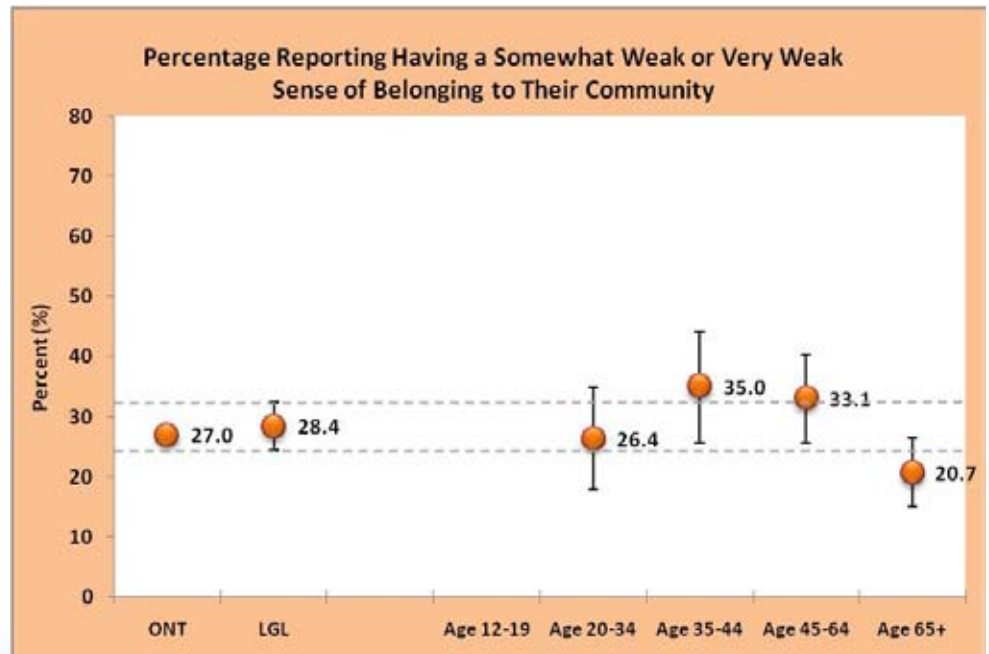
Overall, 21.7% of LGL residents (ages 12+) report 'quite a bit' to 'extreme' life stress, which is similar to the Ontario average.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

### Community Belonging by Age Group

Overall, 28.4% of LGL residents report a 'somewhat weak' or 'very weak' sense of belonging to their community. Younger LGL residents (age 20-34) and older LGL residents (age 65+) appear to feel a greater sense of belonging than residents in the middle age groups (age 35-44 and age 45-64).

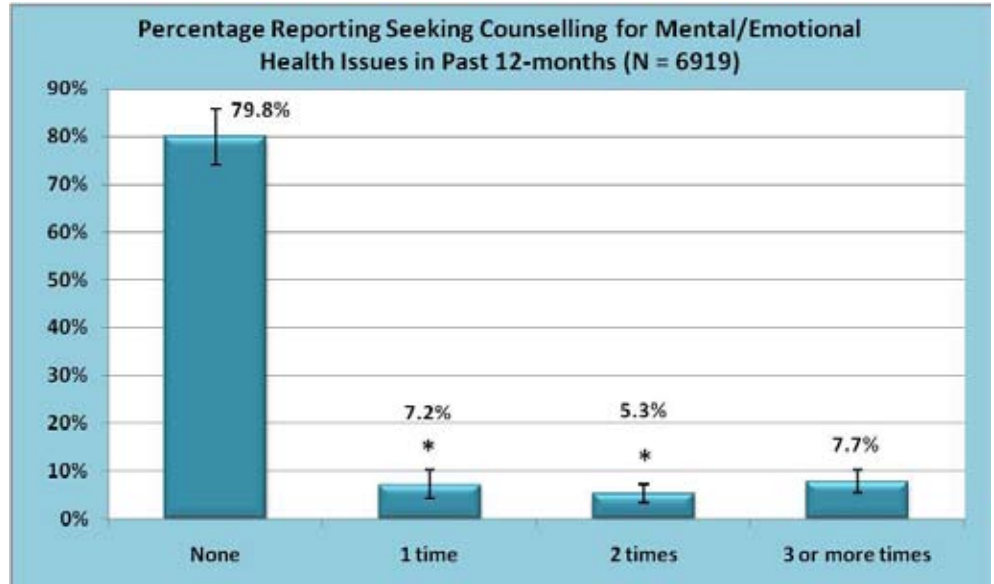


Source: Canadian Community Health Survey 2007/2008. Statistics Canada



**Mental Health Overall**

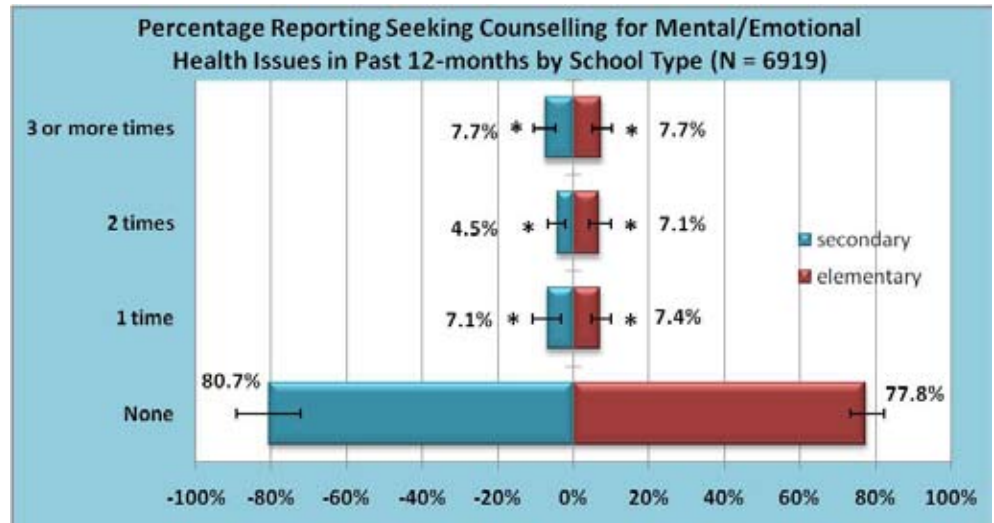
Overall, 20.2% of students in LGL have sought counselling for mental/emotional health issues in the past 12 months.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Mental Health by School**

There are no significant differences in the percentages of students who seek counselling for mental/emotional health issues between elementary and secondary students in LGL.

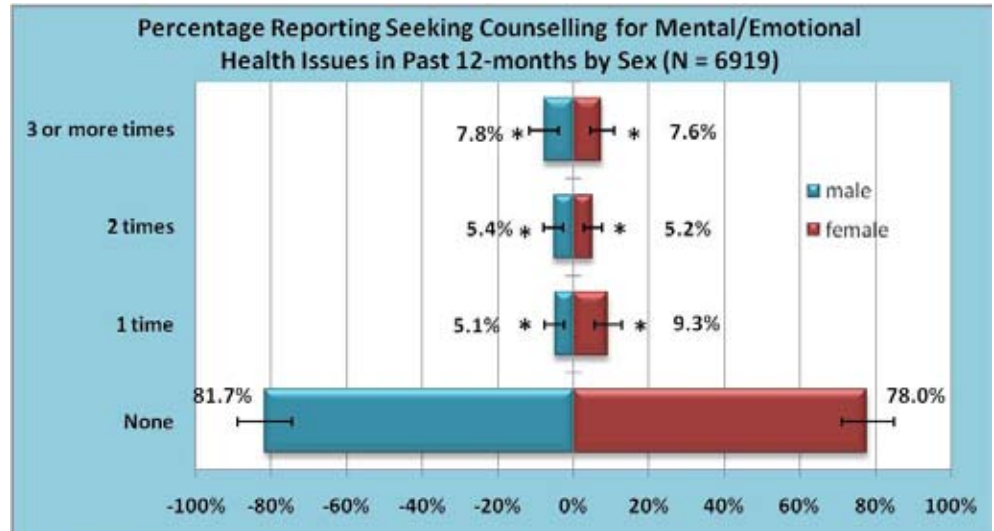


Source: Ontario Student Drug Use and Health Survey, CAMH 2009



**Mental Health by Sex**

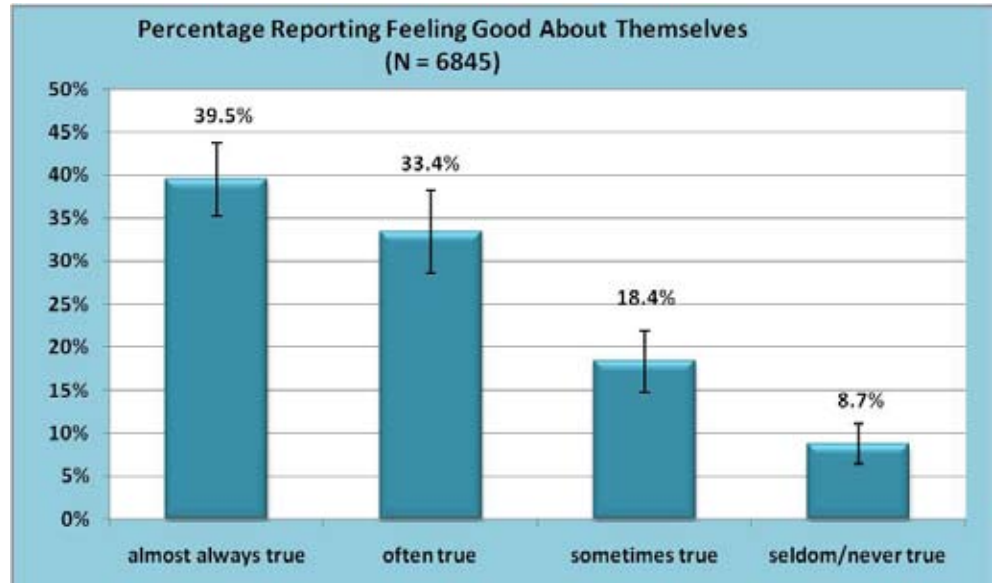
Similar proportions of male and female students in LGL report seeking counselling for mental/emotional health issues in the past 12 months. Overall, close to 1 in 5 students reports seeking counselling for mental/emotional health issues at least once in the past year.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Self Esteem Overall**

Overall, 8.7% of students report that they 'seldom/never' feel good about themselves.

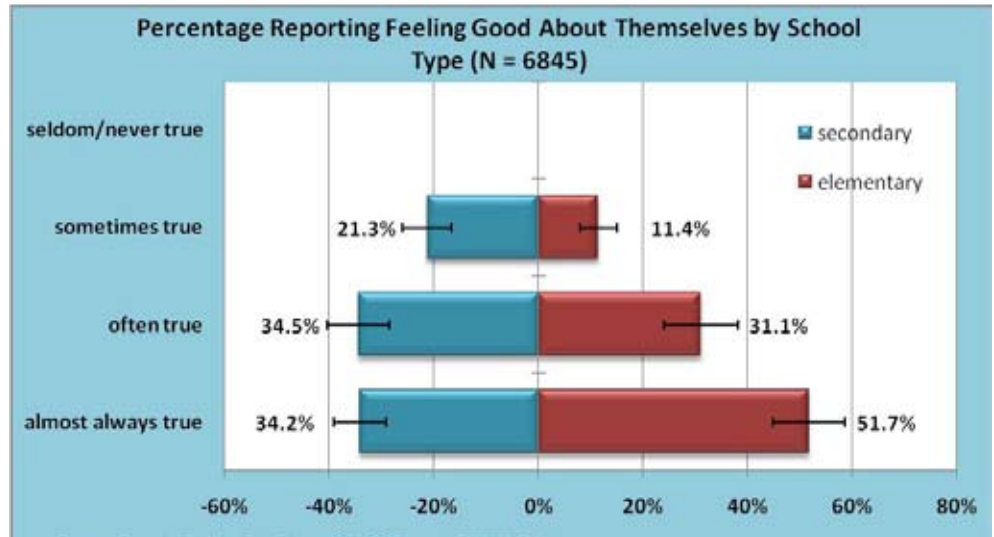


Source: Ontario Student Drug Use and Health Survey, CAMH 2009



**Self Esteem by School**

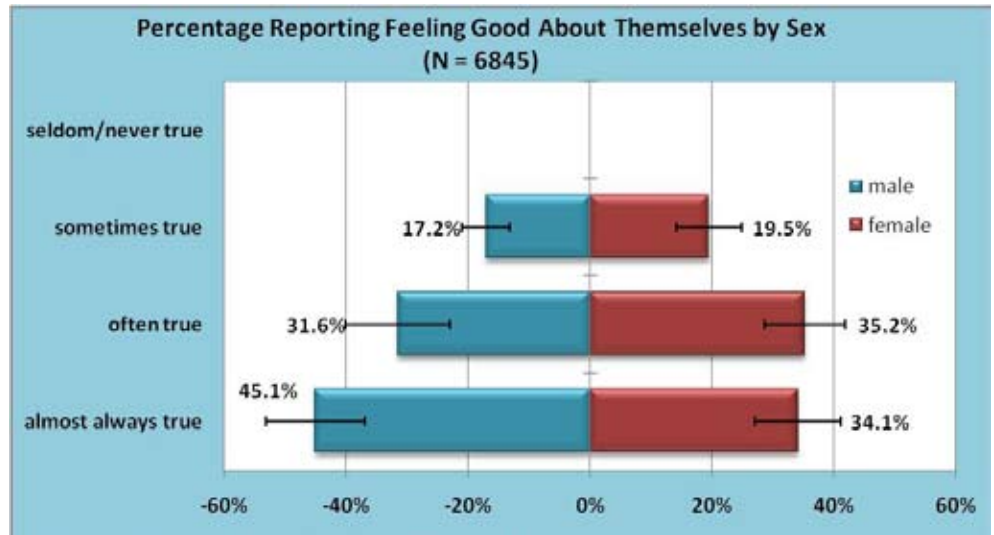
More elementary students in LGL report feeling good about themselves 'almost always' compared to secondary students.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Self Esteem by Sex**

More male students in LGL report feeling good about themselves 'almost always' compared to female students in LGL.

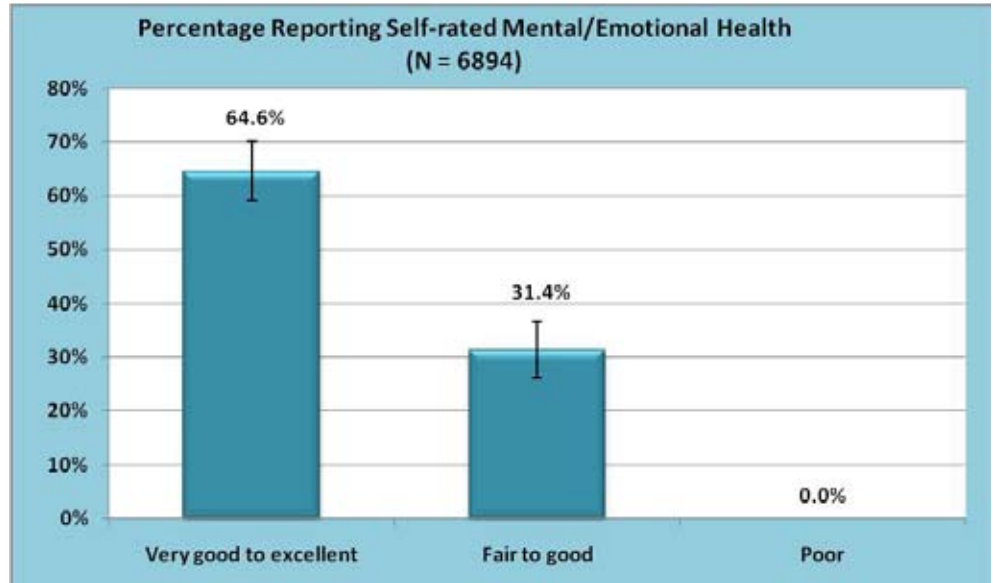


Source: Ontario Student Drug Use and Health Survey, CAMH 2009



**Self-rated Mental Health Overall**

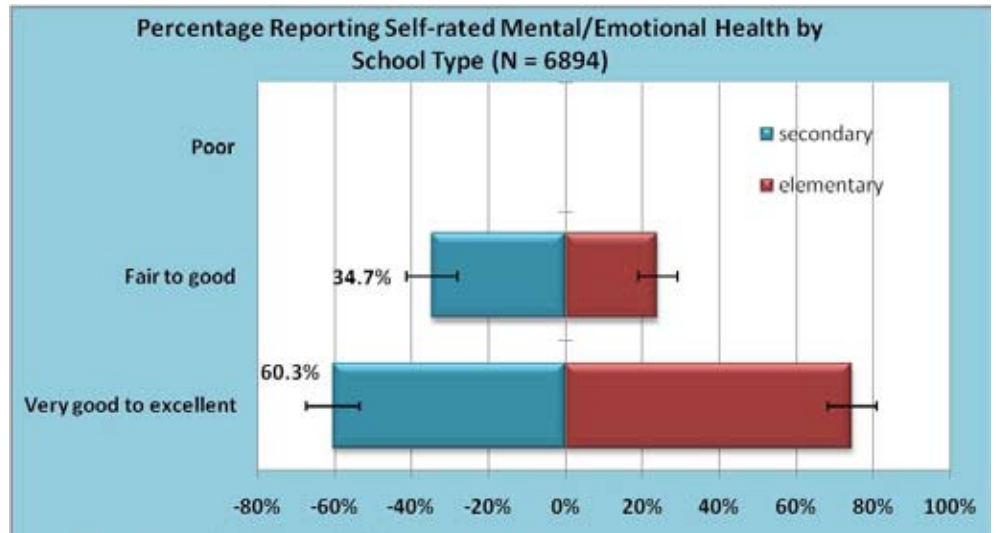
Overall, 31.4% of students in LGL self-rate their mental/emotional health as 'fair to good' and over two-thirds rate their mental/emotional health as 'very good to excellent'.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009

**Self-rated Mental Health by School**

A greater proportion of elementary students in LGL rate their mental/emotional health as 'very good to excellent' compared to secondary students in LGL.

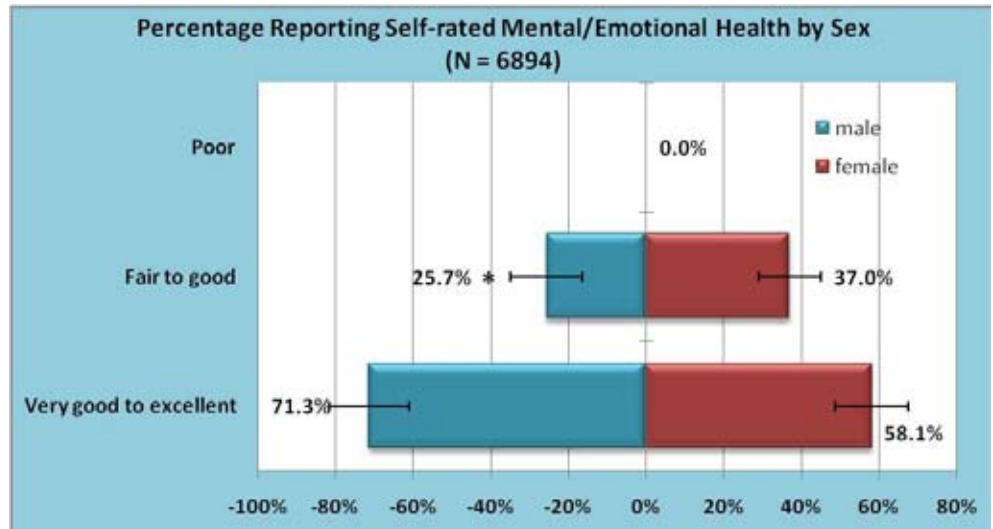


Source: Ontario Student Drug Use and Health Survey, CAMH 2009



### Self-rated Mental Health by Sex

More male students in LGL rate their mental health as 'very good to excellent' compared to female students in LGL.



Source: Ontario Student Drug Use and Health Survey, CAMH 2009



## 5.0 Focus on Income

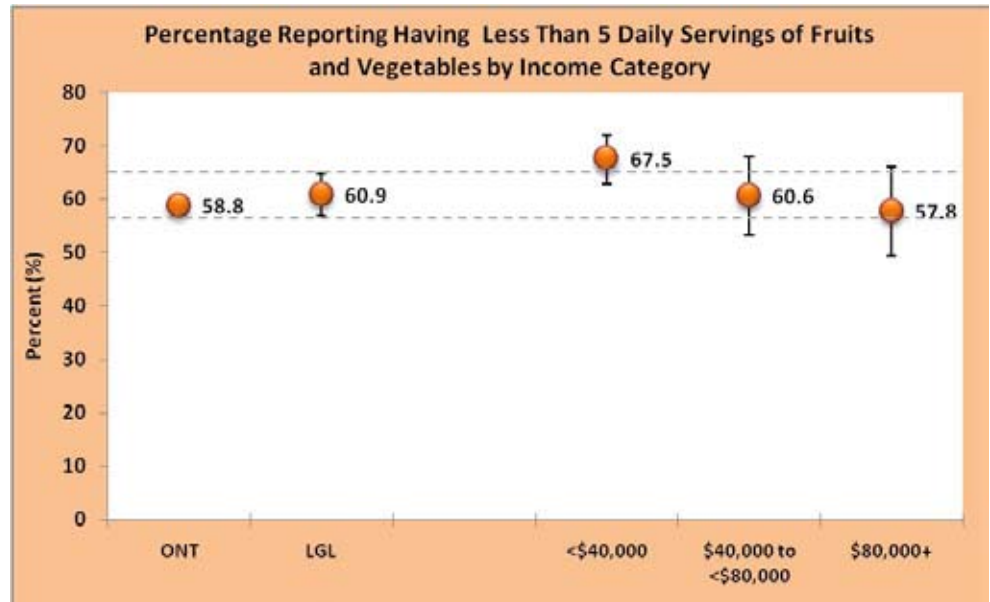
According to the Public Health Agency of Canada, income and social status are recognized as the most important determinants of health and these two factors have a tremendous influence on population health. The relationship between income and health is incredibly complex. In many cases, individuals with lower incomes may lack knowledge about healthy behaviours, lack access to healthy foods, which are often more expensive, lack access to safe recreation opportunities, and experience high levels of stress, which combined with a lack of resources, skills and social support, may lead to unhealthy coping behaviours.<sup>1</sup> So encouraging healthy behaviours is not simply a matter of telling people what is good for them. We also need to address the underlying barriers to a healthy lifestyle.

Both national and local data are presented here. Due to smaller sample sizes, local data cannot be broken down into the lowest income levels as the data become too unstable. The local data give a perspective on how we relate to national data.

1 Public Health Agency of Canada. "2009 Tracking Heart Disease and Stroke in Canada" www.phac-aspc.gc.ca (accessed 6 October 2010)

### Fruit & Vegetable Consumption by Income

*Nationally, 10% more Canadians in the lowest income quintile reported inadequate consumption of vegetables and fruit compared to those in the highest income quintile. This pattern is similar to the local data shown here.*

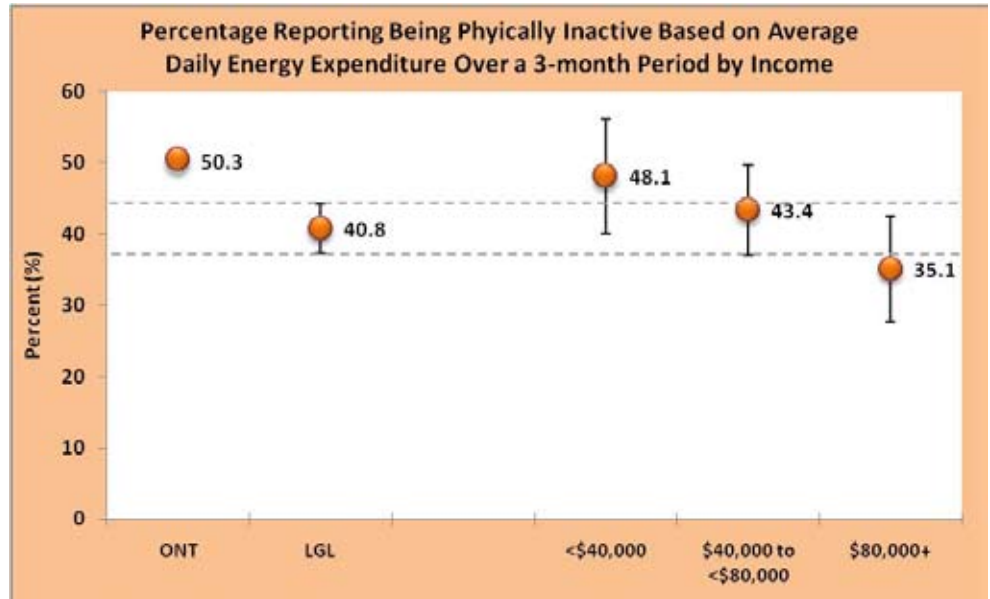


Source: Canadian Community Health Survey 2007/2008. Statistics Canada



**Physically Inactive by Income**

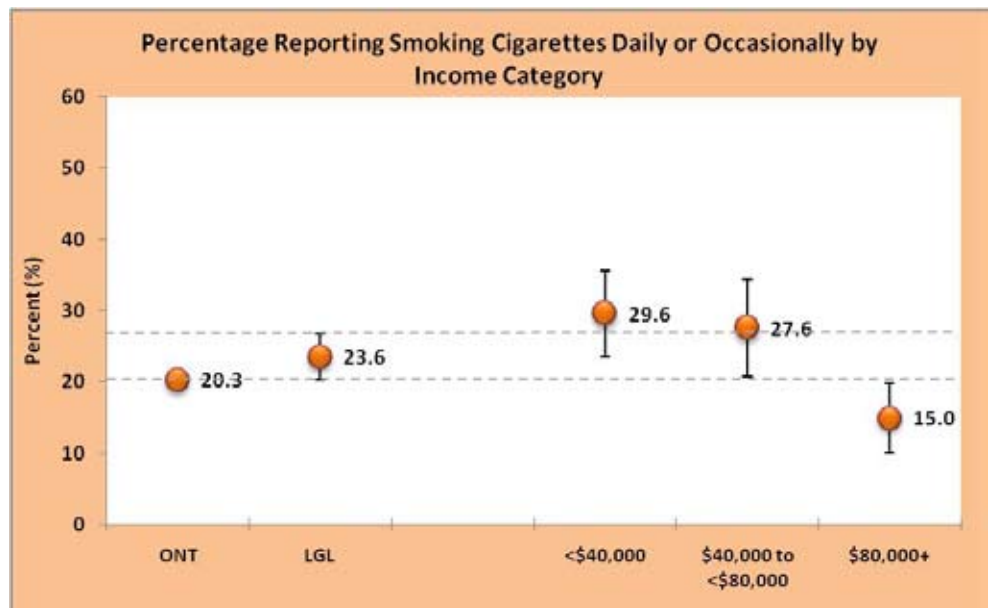
National data shows a similar pattern as fruits and vegetable consumption - rates of physical inactivity are 1/3 higher among Canadians in the lowest income quintile. This is consistent with local data shown here.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

**Smoking by Income**

Rates of daily and occasional smoking decrease significantly as income level increases. Nationally, individuals in the lowest income quintile are almost twice as likely to report daily tobacco smoking than those in the highest income quintile. Local data, shown here, supports this trend.



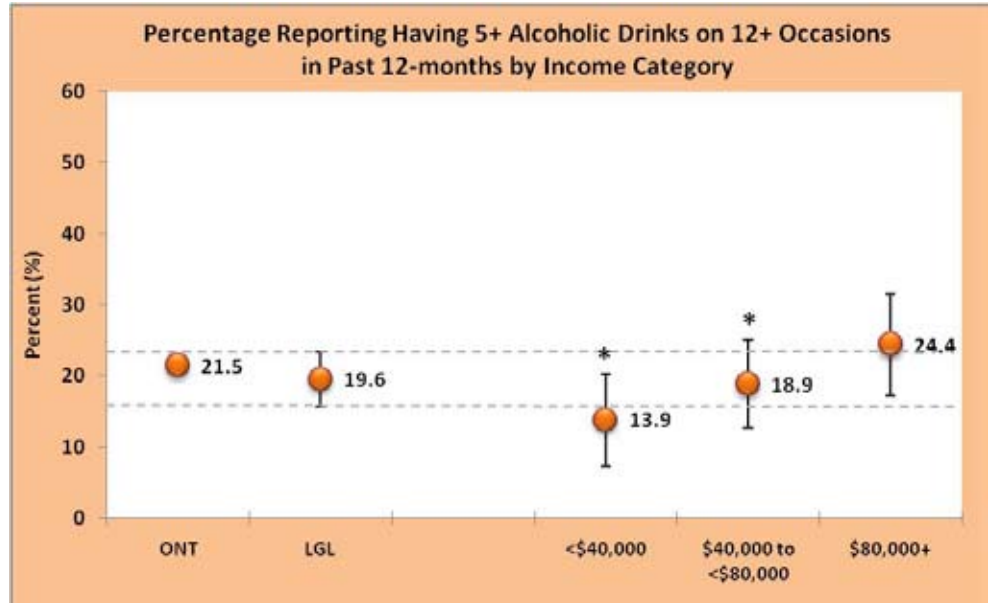
Source: Canadian Community Health Survey 2007/2008. Statistics Canada





**Alcohol Use by Income**

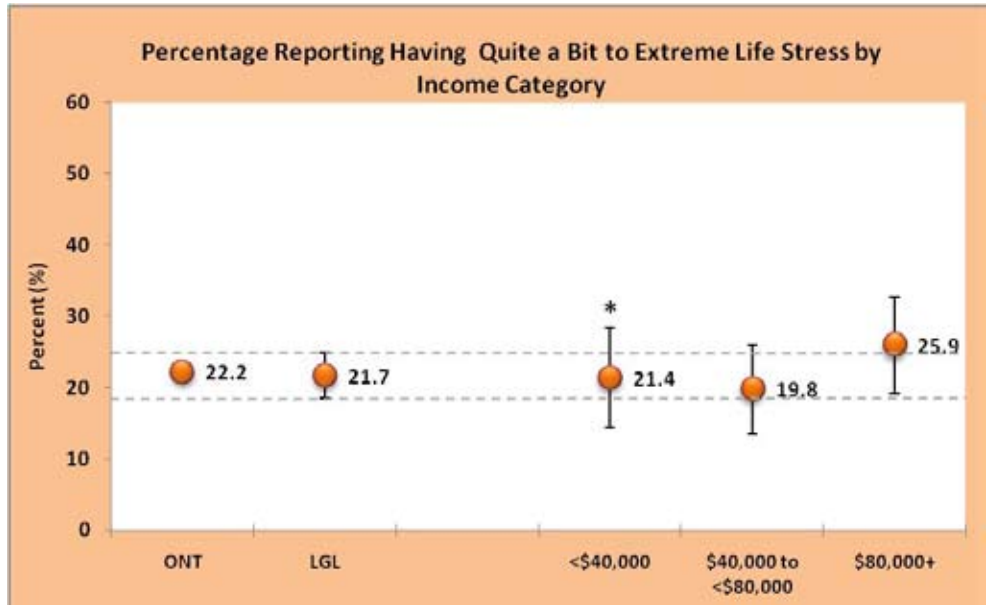
As income increases, the number of residents reporting having 5+ drinks on 12+ occasions in the past 12 months also increases.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada

**Life Stress by Income**

National data shows a u-shaped pattern for stress by income: individuals in the lowest and highest income quintiles experience the highest levels of stress, while Canadians in the middle income quintiles experience lower levels of stress. Locally we are not able to assess stress levels among the individuals with the lowest level of income but it is likely to be the same. The sources of stress are likely to be different among the lowest and highest levels of income.



Source: Canadian Community Health Survey 2007/2008. Statistics Canada



## 6.0 Local Causes of Morbidity and Mortality

The risk factors associated with the six priority areas described in Section 4.0 are important because they can lead to morbidity and mortality. The tables below illustrate the leading causes of morbidity and mortality for LGL residents as indicated by hospital in-patient discharges and mortality database records. Cardio vascular disease was the leading cause of in-patient discharges for residents of LGL in 2007. Diseases of the heart, lungs and vascular system were the leading causes of death in 2005.

<b>Leading Causes of Morbidity by In-patient Discharge LGL 2007 (source: PHPDB)</b>	
<b>Lead Cause Group (ISHMT)</b>	<b># Dschg</b>
Chronic Disease - Cardio Vascular Disease	2,330
Reproductive Health - Live Born Infants (Adult)	1,328
Injury Prevention - Falls (Adult)	646
Chronic Disease - Chronic Obstructive Respiratory Disease (COPD)	488
Infectious Diseases - Pneumonia	326
Cancer - Colorectal	129
Cancer - Lung	90
Neonatal Morbidity - Low Birth weight	89
Reproductive Health - Pregnancy Induced Hypertension	83
Neonatal Morbidity - Preterm Labour/Birth	76

<b>Age Adjusted Leading Causes of Mortality LGL 2005 (source: PHPDB)</b>		
<b>Cause</b>	<b>Rate</b>	<b>Count</b>
Diseases of Heart	144.1	373
Cancer of Lung and Bronchus	59.9	141
Cerebrovascular Diseases	45.2	121
Chronic Obstructive Pulmonary Disease	29.6	76
Accidents and Adverse Effects	28.1	56
Cancer of Colon and Rectum	25.0	58
Diabetes Mellitus	23.7	61
Pneumonia and Influenza	20.0	53
Alzheimer's	15.5	43
Cancer of Breast	13.8	34

\*Rates are per 100,000 population and age-adjusted to the 1991 Canadian standard population.



## 7.0 Assets

An important part of the local community picture is identifying the assets that currently exist. To better understand local assets, the Healthy Communities Partnership developed an electronic survey for stakeholders to complete. The survey collected information about the geographic area that stakeholders serve, populations served, priority areas addressed, social determinants of health addressed and interest in being involved in the Healthy Communities Partnership. A total of 30 stakeholders completed the survey and the information has been used to produce a map (below) which visually identifies which organizations are working where, and with whom. As well, two tables (below) have been developed identifying which organizations are working on which priority areas, and on which determinants of health. These documents help to identify the existing community assets as well as some gaps in the community. Please note, the data in the map and tables are current as of September 30<sup>th</sup>.

### 7.1 Asset map

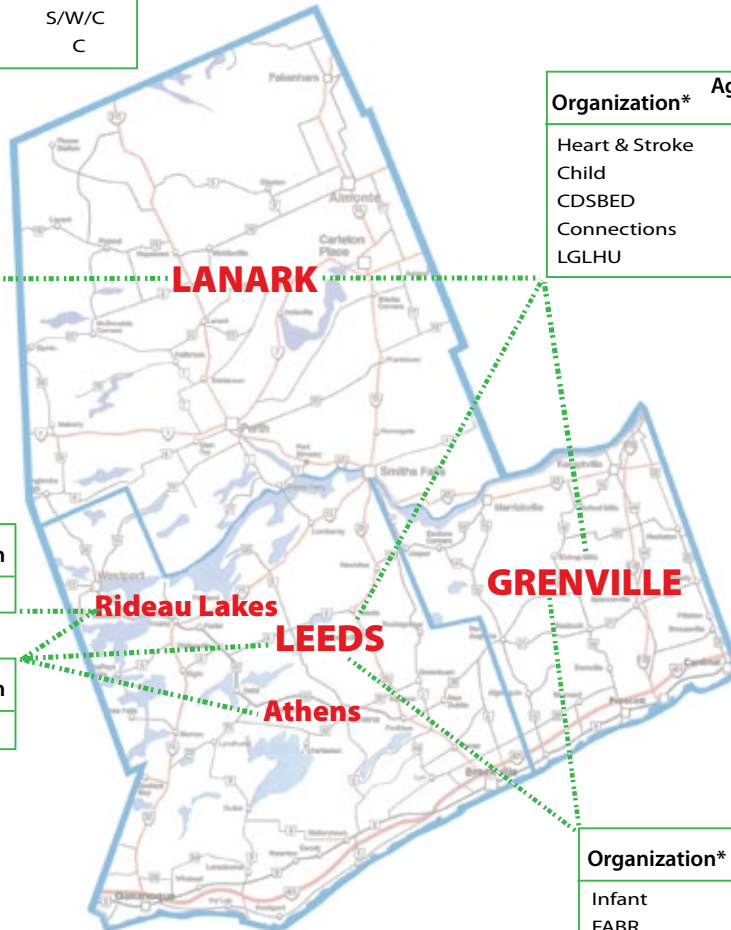
\* The Legend below applies to the map on pg 33 as well as the Tables in section 7.2 and 7.3

<b>LEGEND</b>	
ASK	Active Seniors Koalition
Assault	Assault Response and Care Centre
BBBS-L	Big Brothers Big Sisters of Lanark County
Best Start	Best Start Working Group (Lanark County)
CDSBEO	Catholic District School Board of Eastern Ontario
CHC	Country Roads Community Health Centre
Child	Child Development Centre
Connections	Connections CAPC/CPNP
CROW	Children's Resources on Wheels/Ontario Early Years Centre
Doors	Open Doors for Lanark Children and Youth
Employ	The Employment & Education Centre
FABR	Frontenac Arch Biosphere Reserve
Girls Inc	Girls Incorporated of Upper Canada
Heart & Stroke	Heart & Stroke Foundation of Ontario
Infant	Infant and Child Development Program, Leeds and Grenville
L-G	United Counties of Leeds and Grenville Human Service Division
LGLDHU	Leeds-Grenville and Lanark District Health Unit
MDS	Lanark County and the Town of Smiths Falls Municipal Drug Strategy
REAL	Rideau Environmental Action League
Rehab	Leeds-Grenville Rehabilitation and Counselling Service
Safe	Safe Communities Coalition of Brockville, Leeds and Grenville



Organization*	Age Group Served	Location
Best Start	0-6	S/W/C
CROW	0-6	C
Doors	0-19	S/C
ASK	35+	C
BBBS-L	0-65+	S/W/C
MDS	0-65+	C

Organization*	Age Group Served	Location
Heart & Stroke	0-19	S/C
Child	0-19	S/C
CDSBED	0-19	S
Connections	0-54	C
LGLHU	0-65+	S/W/C



Organization*	Age Group Served	Location
CHC	0-65+	S/C

Organization	Age Group Served	Location
Rehab	20-65+	W/C

Organization*	Age Group Served	Location
Infant	0-6	C
FABR	7+	S/W/C
Girls Inc.	7-19	S/C
Assault	7-65+	S/W/C
Employ	13-64	S/W/C
LG	0-64	C
Safe	0-65+	S/W/C

**Legend**

- S = School
- W = Workplace
- C = Community

\*See full organization names on pg 32



## 7.2 Table of work being done on priorities

	Awareness	Skill Building	Supportive Environments	Policy
<b>Nutrition/access to nutritious food</b>	BBBS-L CDSBEO CHC Connections CROW Employ FABR Heart & Stroke L-G LGLDHU	BBBS-L CDSBEO CHC Connections CROW FABR Heart & Stroke LGLDHU	ASK BBBS-L CDSBEO CHC Connections FABR Heart & Stroke LGLDHU REAL	CHC Heart & Stroke LGLDHU
<b>Build environment/ active transportation</b>	BBBS-L Employ FABR Heart & Stroke LGLDHU Rehab	BBBS-L Employ FABR Heart & Stroke LGLDHU	Employ FABR Heart & Stroke L-G LGLDHU Rehab	Employ Heart & Stroke LGLDHU
<b>Recreation/ Sport and physical activity</b>	ASK BBBS-L CHC CROW Employ FABR Heart & Stroke L-G LGLDHU Rehab Safe	BBBS-L CHC CROW FABR Heart & Stroke LGLDHU Safe	ASK BBBS-L CHC FABR Heart & Stroke L-G LGLDHU REAL Rehab	CHC Heart & Stroke LGLDHU
<b>Prevention of tobacco use/ exposure</b>	BBBS-L CDSBEO CHC Connections Employ Heart & Stroke LGLDHU MDS	BBBS-L CDSBEO CHC Connections LGLDHU MDS	BBBS-L CDSBEO CHC Connections LGLDHU MDS	CDSBEO CHC Heart & Stroke LGLDHU MDS



	<b>Awareness</b>	<b>Skill Building</b>	<b>Supportive Environments</b>	<b>Policy</b>
<b>Prevention of alcohol/ drug misuse</b>	BBBS-L CDSBEO CHC Connections Employ L-G LGLDHU MDS	BBBS-L CDSBEO CHC Connections LGLDHU MDS	BBBS-L CDSBEO Connections L-G LGLDHU MDS	LGLDHU MDS
<b>Injury prevention</b>	ASK BBBS-L CDSBEO Connections CROW Employ LGLDHU MDS Safe	BBBS-L CDSBEO Connections Employ LGLDHU MDS Safe	ASK BBBS-L CDSBEO LGLDHU MDS Safe	CDSBEO LGLDHU MDS Safe
<b>Mental health</b>	Assault BBBS-L CDSBEO CHC Connections CROW Doors Employ L-G LGLDHU MDS Rehab Safe	Assault BBBS-L CDSBEO CHC Connections CROW Doors Employ MDS Rehab	ASK Assault BBBS-L CDSBEO CHC L-G MDS Rehab	Assault BBBS-L CHC MDS



### 7.3 Table of work being done on determinants of health

	Income & social status	Social support networks	Education & literacy	Employment / working conditions	Social environments	Physical environments	Personal health practices & coping skills	Healthy child development	Health services
ASK		x			x	x			
Assault	x	x	x	x	x	x	x	x	x
BBBS-L		x	x		x		x	x	
Best Start			x					x	
CHC	x	x	x	x	x	x	x	x	x
Child	x	x			x	x	x	x	x
Connections	x	x	x	x	x	x	x	x	x
CROW			x		x		x		
Employ	x	x	x	x	x		x	x	
Heart & Stroke	x	x			x	x	x	x	x
Infant								x	
L-G	x	x	x	x			x	x	
LGLDHU	x	x	x	x	x	x	x	x	x
MDS					x	x	x		
Open Doors		x			x			x	x
REAL						x			
Rehab	x	x	x	x	x	x	x		
Safe					x	x	x		
	<b>9</b>	<b>12</b>	<b>10</b>	<b>7</b>	<b>14</b>	<b>11</b>	<b>13</b>	<b>12</b>	<b>7</b>

This information will be supplemented by the completion of a 'Network Map.' Health Nexus (the organization completing the Network Mapping) explains that the Network Map will collect data from multiple individuals with emphasis on the relationship as the unit of analysis. This information will then be translated into visual maps that can assist in building and sustaining strong networks of collaboration for healthy communities and help to enable partnerships to see and act on opportunities to collaborate and connect.



In addition to identifying the work being done by stakeholders, several scans identifying local assets have been completed:

#### **Environmental Scan of Health Promotion Policies in Champlain District School-based Settings (2007)**

- Most commonly identified policies were:
  - Elementary Schools: daily physical activity and Healthy Choices in Vending Machines
  - Secondary Schools: Healthy eating options in cafeterias, mandatory credit of physical education, participation in 'Eat Smart' cafeteria certification program
- No board has an active transportation policy or procedure in place (as of 2007)

#### **Ontario Heart Health Network Collaborative Policy Scan (2009)**

- Existing policies identified in LGL were:
  - Policy supporting establishment of Farmers Markets
  - Policy supporting welfare supplements being used to purchase nutritious foods
  - Healthy food access maps promoted
  - Regional/district/county/municipality Interim Land Use Policies to address lack of open spaces for recreation in apartment complexes and other multi-unit dwellings and Vacant Lots Policy to establish guidelines for public use of private land and city-owned vacant lots
  - Existence of a regional/district/county/municipality Parks Master Plan, Recreation Master Plan, and an Official Plan
  - Existence of a regional/district/county/municipality public transportation system
  - Municipal Alcohol Policy, policy that supports Safer Bars training, policies to reduce/prevent service to minors or to intoxicated patrons (above provincial requirements)
  - Policy that bans tobacco use within designated distance of public entrances and exits to regional/district/county/municipality buildings providing local government services

#### **Community Gardens Inventory (2010)**

- Identifies 5 established community gardens and 2 in the process of getting organized in LGL

#### **Food Access Inventory (2010)**

- Identifies 17 emergency food programs, 3 food action and skill development programs, and 12 food support programs in LGL

#### **Municipal Recreation Inventory (2010)**

- Identifies local recreation opportunities in LGL

#### **Community Services Inventory (2010)**

- Identifies food and nutrition-related programs for seniors, exercise programs for seniors and home support programs in Lanark and in Leeds-Grenville





## 8.0 Next Steps/Timeline

The Healthy Communities Partnership will continue to collect data related to the six priority areas and will continue to analyze this data during 2010. Members of the Interim Steering Committee will be completing focus groups in the community to gain feedback about what the community sees as priority areas. This information, along with the data collected, and will be used to identify recommended actions in the priority areas for Lanark, Leeds and Grenville in late 2010.

Once recommended actions are identified, the community will be consulted again to gain feedback about the recommended actions identified in early 2011. The community will also be asked to provide input on which of the six topic areas to focus on for policy change. After the community feedback is reviewed and the recommended actions are finalized, the Healthy Communities Partnership will begin to focus on initiatives that mobilize the community towards policy change in the spring of 2011 and beyond. At the same time, the Healthy Communities Partnership will begin to mobilize the community around the recommended actions identified in the plan. The recommended actions that are identified by the Healthy Communities Partnership will subsequently be used to inform the Healthy Communities Fund grant stream in its decision making.

As well, the HCP LLG will launch a website housing the many resources that have been identified and developed by the partnership.

### The Healthy Communities Partnership Website

We are working in partnership to make the healthy choice, the easy choice. It is our hope that the Healthy Communities Partnership website will make connecting with each other and our community easier.

In addition to the website acting as a communication tool, valuable resources such as our community profile, a network map, local reports and resources as well as event information will be offered.

**Watch for the launch of the Healthy Communities website Fall 2010.**

### Website Features...

- Healthy Communities Fund Background (Ministry of Health Promotion and Sport)
- Partnership Information
  - Our Vision for Lanark, Leeds, & Grenville
  - Becoming a Partner
  - Our Partnership
    - Committees
      - Minutes and Agendas
    - List Serve
  - Events
    - Upcoming Events
    - Past Events
  - Media Coverage
- Library
  - Community Profile
  - Local reports and resources
  - Network Map
  - Surveys and Results
  - Healthy Communities Consortium resources
  - Links
- Contact Information



### Lanark, Leeds & Grenville HCP Timeline

	2010			2011		
	October	November	December	January	February	March
Recruitment of Key Partners						
Plan /Host Healthy Community Partnership Day						
Identify Core and Peripheral Partners						
Compile Initial Community Profile - Demographics, Assets, Priority Areas						
Network Map: Survey of Partners						
Community Input on Priority Areas						
Choose Priority Setting Process						
Finalize Community Profile						
Identify Recommended Actions						
Community Feedback on Recommended Actions and Input on Policy Direction						
Finalize Community Plan with Profile, Recommended Actions and Policy Direction						
Mobilize Community to Address Recommended Actions						
Policy Development and Implementation						

**Important upcoming dates:**

**November 10<sup>th</sup> 2010:**

The Healthy Communities Partnership: Lanark, Leeds and Grenville (HCP LLG) will receive training on Structure and Governance from the Tamarack Collaborating Institute, and initial decisions will be made in this arena.

**December 10<sup>th</sup>, 2010:**

The HCP LLG will receive training on priority setting from The Health Communication Unit and will choose parameters for the priority setting process.

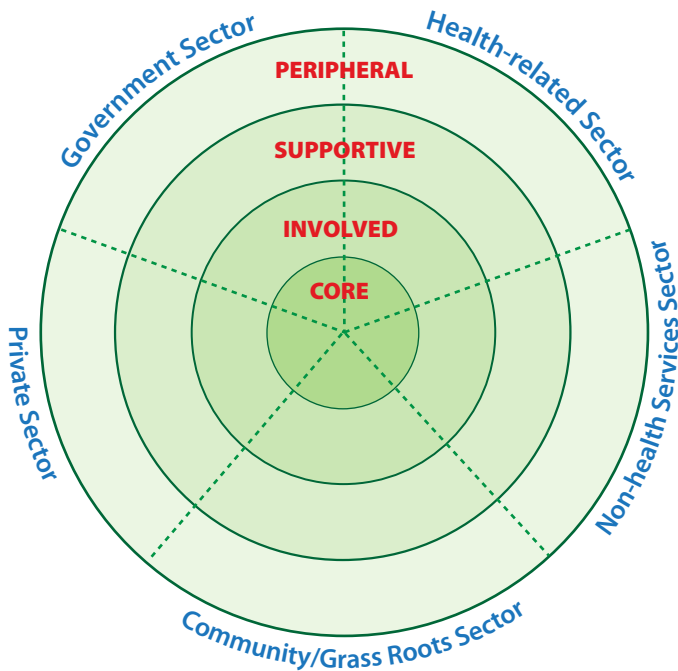
**March 2011:**

Release of Network Map and training provided on interpretation and use of map.



## 9.0 Stakeholder Wheel and Interpretation

The Stakeholder Wheel developed by The Health Communication Unit provides a tool for partners to identify their sector and their preferred level of involvement in the Healthy Communities Partnership.



The following definitions will help partners to place themselves on the wheel:

**Core:** stakeholders who are actively involved in the functioning of the partnership.  
i.e. Members of the Steering Committee/ Advisory Group/Planning Table – meeting at least quarterly - to be determined by the Partnership, once formed and described in the structure and governance plan.

**Involved:** stakeholders who are frequently consulted as part of the partnership.  
i.e. Members of task force/topic specific/ community specific/age specific planning tables

**Supportive:** stakeholders who provide some form of specific support to the partnership, such as participating on a specific task force  
i.e. Member of ad hoc committee/workgroup focused on a specific policy development initiative

**Peripheral:** stakeholders who are kept informed of the progress and work of the partnership, but are not directly involved in the work  
i.e. Linked to this partnership through a network/ knowledge exchange (e.g. list serve, newsletter, opportunities to participate in events/workshops

Members can occupy more than one level of involvement.



## Appendix 1: Definition of CCHS Variables Analyzed

Variable name	Description	Timeframe/details
Leisure time and physical inactivity	This variable categorizes respondents as being “active”, “moderately active”, or “inactive” in their leisure time based on the total daily Energy Expenditure values (kcal/kg/day).	This variable is a measure of the average daily energy expended during leisure time activities by the respondent in the past 3-months.
Current daily or occasional smoker	At the present time, do you smoke cigarettes daily, occasionally or not at all?	At time of survey.
5+ drinks on one occasion	How often in the past 12 months have you had 5 or more drinks on one occasion?	The word drink means: one bottle or can of beer or a glass of draft, one glass of wine or a wine cooler, or one drink or cocktail with 1 and a 1/2 ounces of liquor.
Less than recommended 5 daily servings of fruit and vegetables	This variable classifies the respondent based on the total number of times per day he/she eats fruits and vegetables.	Based on FVCDTOT (fruit and vegetable consumption daily total). The CCHS measures the number of times (frequency), not the amount consumed.
Perceived life stress	Thinking about the amount of stress in your life, would you say that most days are: (not at all stressful, not very stressful, a bit stressful, quite a bit stressful, or extremely stressful)?	Respondents aged 15 and over.
Sense of belonging to local community	How would you describe your sense of belonging to your local community? Would you say it is: (very strong, somewhat strong, somewhat weak, or very weak)?	At time of survey.



NOTES:





For more information on the Lanark, Leeds & Grenville  
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